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IN THE

Supreme Court of the United States

Arthur P. Christie, Anthony L. Alford, Daniel A. Deighton, Frederick W. Jennart, David N. Harvey, M.D., Michael A. Hellwege, M.D., F. Hunt Sanders, M.D., Richard J. Sullivan, M.D., Titus A. Taube, M.D., C. Scott Edenfield, M.D., Rahil Kazi, M.D., Richard L. Heaton, M.D., Britton L. Pilcher, M.D., Santanu Das, M.D., Thomas C. Johnson, M.D., Richard B. Ellis, M.D., and Hospital Authority of Houston County d/b/a Houston Medical Center, PETITIONERS

v.

Russell E. Adkins, M.D.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

Rush S. Smith, Jr.
HALL, BOOTH, SMITH & SLOVER, P.C.
1180 West Peachtree Street
Suite 900
Atlanta, GA 30309
(404) 954-5000

Paul R. Koster*
Counsel of Record
Cynthia M. Daley
DALEY, KOSTER & LAVALLEE, LLC
Overlook I
2849 Paces Ferry Road
Atlanta, GA 30339
(678) 213-2401

Attorneys for Petitioners

CURRY & TAYLOR • WASH D.C. • (202) 393-4141 • USSCINFO.COM

QUESTION PRESENTED

Whether federal courts should recognize an evidentiary privilege against compelled disclosure of confidential, internal medical peer review communications under Rule 501 of the Federal Rules of Evidence.

RULE 29.6

Petitioner Hospital Authority of Houston County d/b/a Houston Medical Center does not have a parent corporation, and no publicly held company owns 10% or more of its stock.

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OPINIONS BELOW

The district court's unpublished order recognizing a medical peer review privilege against compelled disclosure of confidential medical peer review communications can be found at 2004 U.S. Dist. LEXIS 23010 (M.D. Ga. Nov. 10, 2004). (Pet. App. 16a-21a). The district court's unpublished order granting Petitioners' motion for summary judgment can be found at 2006 U.S. Dist. LEXIS 25668 (M.D. Ga. May 2, 2006). (Pet. App. 22a-47a). The Eleventh Circuit's opinion declining to recognize a medical peer review privilege and reversing the district court's order granting Petitioners' motion for summary judgment is reported at 488 F.3d 1324 (11th Cir. 2007). (Pet. App. 1a-15a). The Eleventh Circuit's unpublished order denying Petitioners' petition for rehearing *en banc* is reproduced in the Appendix hereto. (Pet. App. 48a-49a).

JURISDICTION

The Eleventh Circuit denied Petitioners' petition for rehearing *en banc* on August 16, 2007. (Pet. App. 48a-49a). This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

RELEVANT PROVISIONS INVOLVED

FED. R. EVID. 501:

> Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority,

> the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law.

STATEMENT

This case presents the question of whether federal courts should recognize an evidentiary privilege against compelled disclosure of confidential, internal medical peer review communications under Rule 501 of the Federal Rules of Evidence.

All fifty states and the District of Columbia have recognized a medical peer review privilege. The states strongly believe that a hospital's internal peer review process promotes public health and safety by ensuring quality patient care and fosters vital standards of care and treatment in hospitals. All states recognize that confidentiality is essential to the successful functioning of medical peer review and that compelled disclosure in litigation would eviscerate the public health benefits provided by medical peer review.

The Eleventh Circuit below added its voice to the growing disarray in the lower courts over how to reconcile this Court's decision in *University of Pennsylvania v. EEOC*, 493 U.S. 182 (1990) with its decision in *Jaffee v. Redmond*, 518 U.S. 1 (1996). This

Court in *University of Pennsylvania* declined to recognize a privilege for academic peer review of tenure decisions on the ground that such privilege "has no . . . historical or statutory basis," *id.* at 195, and appeared to weigh the value of the confidentiality against the value of disclosure in a particular case. The Court in *Jaffee*, in contrast, recognized a psychotherapist-patient privilege despite a lack of common law history or statutory guidance on the ground that such a privilege was essential for confidence and trust, served important public ends and was consistent with state rules. Furthermore, in apparent conflict with *University of Pennsylvania*, the Court in *Jaffee* expressly rejected weighing the value of confidentiality against the value of disclosure in a particular case.

The Eleventh Circuit's decision squarely contradicts *Jaffee*, presents a conflict in approach with the Fifth Circuit's decision in *United States v. Harris Methodist Ft. Worth*, 970 F.2d 94 (5th Cir. 1992), and further adds to the significant confusion in the lower courts over whether federal courts should follow the states and recognize a medical peer review privilege in light of *University of Pennsylvania* and *Jaffee*. Moreover, the Eleventh Circuit's decision ensures an intractable division between federal and state courts on an important issue of health and safety. Only this Court can reconcile its two decisions, and this case presents an excellent vehicle to provide guidance on this important issue.

A. The Importance Of Medical Peer Review

1. *Effective Peer Review Is Essential To Quality Health Care*

Medical peer review is the process by which physician members of a hospital's medical staff review medical errors of other members of the medical staff and by the hospital as a whole, evaluate the qualifications of applicants for new privileges or for renewal of privileges, and effect disciplinary actions against medical staff members. *See* Christopher S. Morter, Note, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting*, 74 VA. L. REV. 1115, 1117 (1988).

Peer review is essential to the quality of healthcare in this country. According to an April 2006 study, 250,246 potentially preventable deaths occurred in this country between 2002 and 2004, making medical errors "a leading cause of death in the U.S." *See HealthGrades Quality Study: 3rd Annual Patient Safety in American Hospitals Study* at 2, 4 (Apr. 2006), at www.healthgrades.com/media/dms/pdf/PatientSafetyInAmericanHospitalsStudy2006.pdf.

As the courts and commentators have observed, peer review enhances the quality of patient care through effective supervision of healthcare professionals, elimination from the healthcare system of those who should not practice, and treatment of those whose abilities are impaired and in need of rehabilitation. *See, e.g., Nilavar v. Mercy Health Sys.*, 210 F.R.D. 597, 600 (S.D. Ohio 2002) (peer review process "helps root out incompetence in the medical profession, which, in turn, leads to a higher overall level

of healthcare for patients. In addition, patients' awareness of this practice fosters a level of reassurance that they are receiving proper care"); Daniel Mulholland, III & Phil Zarone, *Waiver of the Peer Review Privilege, A Survey of the Law*, 49 S.D. L. REV. 424, 424 (2003/2004) ("[T]he hospital peer review system is the only meaningful, ongoing process by which medical care is monitored and evaluated and inferior care is dealt with through sanctions that prevent substandard practitioners from causing harm to patients."). As such, the work of medical peer review committees has been described as "life saving." *Weekoty v. United States*, 30 F. Supp. 2d 1343, 1344 (D.N.M. 1998).

The universal acceptance of peer review as the means by which a hospital and its medical staff scrutinize a physician's credentials and monitor the quality of care that is provided is reflected both in state law granting immunity to medical review participants and protecting the confidentiality of medical review proceedings, see, e.g., O.C.G.A. §§ 31-7-133 (2007), 31-7-143 (2007), and in the standards for hospital accreditation published by the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO"). JCAHO, the leading hospital accreditation body in the United States, requires medical staff committees to participate in efforts to measure outcomes and processes and to evaluate "individuals with clinical privileges whose performance is questioned as a result of the measurement and assessment activities." JCAHO, 2000 Hospital Accreditation Standards 303 (2000). The policy underlying the JCAHO standards is "to improve the quality of care provided to the public." Id. at ii. Similarly, the policy underlying state statutes protecting peer review activities is to "foster the

delivery of quality medical services." *See, e.g., Patton v. St. Francis Hosp.*, 539 S.E.2d 526, 528 (Ga. App. 2000).

2. Effective Peer Review Requires Confidentiality

Medical peer review can only be effective where the physicians engaged in the reviewing activities are able to maintain a frank, candid exchange of ideas. Full and fair evaluation of the quality of care of either an individual physician or an institution requires that the reviewing physicians be freely able to discuss and to criticize, if necessary, the actions taken by their colleagues. If committee members fail to engage in a candid evaluation of their fellow physicians' qualifications and actions, poor quality care will go uncorrected, and incompetent or impaired physicians will be allowed to continue practicing.

For this reason, every state and the District of Columbia has balanced the important interest in allowing litigants access to evidence against the enormous health and safety benefits of keeping medical peer review information confidential and has concluded that the balance favors recognizing a privilege for medical peer review. (Pet. App. 6a); Weekoty, 30 F. Supp. 2d at 1346-47 ("noting "at least forty-six states [and the District of Columbia] now have statutes that protect the work of medical peer review committees . . . from discovery or introduction as evidence at trial" and citing state statutes and sources listing state statutes) (internal citations and quotations omitted). These protections take a variety of forms, and arise both from statutes and from judicial decisions, but all protect the sanctity of medical peer review proceedings.

For example, Georgia's peer review privilege applies in "any civil action," including those actions where a physician is challenging the peer review process itself. *See Patton*, 539 S.E.2d at 529-30. Similarly, Idaho's statute states that "all peer review records shall be confidential and privileged, and shall not be directly or indirectly subject to subpoena or discovery proceedings or be admitted as evidence, nor shall testimony relating thereto be admitted in evidence, or in any action of any kind in any court or before any administrative body, agency or person for any purpose whatsoever." Idaho Code § 39-1392b (2007). Some states, such as Georgia and Michigan, protect peer review information even when it is disclosed to certain third parties – the sort of disclosure that can defeat less robust evidentiary privileges. *See Emory Clinic v. Houston*, 369 S.E.2d 913, 914 (Ga. 1988); Mich. Code § 333.2632 (2007).

State courts and legislatures recognize several vital public policies behind the enactment of these statutes. For example, Georgia's peer review statute reflects the "legislature's intent to foster the delivery of quality medical services by protecting the confidentiality of peer review records and preserving the candor necessary for the effective functioning of hospital medical review committees." *Patton*, 539 S.E.2d at 528. Idaho's legislature found that protecting peer review is important "for the purposes of reducing morbidity and mortality, [and] enforcing and improving the standards of medical practice in the state of Idaho." Idaho Code § 39-1392 (2007). The Minnesota Supreme Court has explained that "[t]hese statutes, and similar statutes in many other states, are designed to serve the strong public interest in improving the quality of health care." *Kalish v. Mount Sinai Hospital*, 270 N.W.2d

783, 785 (Minn. 1978). With respect to its peer review privilege, the Virginia Supreme Court observed "[t]he obvious legislative intent is to promote open and frank discussions during the peer review process among health care providers in furtherance of the overall goal of improvement of the health care system. If peer review information were not confidential, there would be little incentive to participate in the process." *HCA Health Servs. of Va. v. Levin*, 530 S.E.2d 417, 420 (Va. 2000). Finally, in surveying the legislative history of its state's law, the North Dakota Supreme Court found that "concerns were expressed that physicians would be unwilling to serve on quality assurance committees, and would not feel free to openly discuss the performance of other doctors practicing in the hospital, without assurance that their discussions in committee would be confidential and privileged. It was this purpose to encourage frank and open physician participation, and the resulting improvement in patient care, which underlies the privilege." *Trinity Medical Ctr. v. Holum*, 544 N.W.2d 148, 155 (N.D. 1996).

The Eleventh Circuit's decision allowing a plaintiff unfettered access to each and every peer review file at a hospital contradicts the states' recognition of the medical peer review privilege and has adverse consequences far beyond the parties before this Court. Such a decision weakens the peer process at every hospital, making physicians unwilling to participate in the vital peer review activity of eliminating mistakes or incompetence among doctors for fear that their participation will lead to litigation against themselves or their professional colleagues. A weakened system of self-regulation among the physician community puts at risk the lives of thousands of individual patients who rely each year on hospitals

and their medical staffs for life-saving treatment and care.

Notably, the harm suffered by the evisceration of the medical peer review privilege is not an abstract theory. Indeed, Petitioners produced evidence in this case demonstrating that upon the required disclosure of peer review information in *Marshall v. Americus-Sumter County Hosp. Auth.*, 2002 U.S. Dist. LEXIS 26822 (M.D. Ga. Nov. 22, 2002), a similar case brought by the same plaintiff's counsel who initially brought this case, physicians in Americus dramatically limited their participation in the peer review process and resigned from various hospital peer review functions. (R1-61-Ex. A at ¶ 6). The Eleventh Circuit's decision opens the door to this result occurring at every hospital and, as such, places patient care at risk.

B. Proceedings Below

Petitioners are the Houston Medical Center ("Hospital"); fourteen members of the Hospital's Medical Executive Committee ("MEC"), a peer review organization within the Hospital responsible for making recommendations regarding staff appointments and re-appointments, clinical privileges, and corrective action; and two members of the Hospital's administration (collectively referred to as "Healthcare Professionals").[1] Respondent Dr. Russell E. Adkins is an African-American physician specializing in the area of urology

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[1] Along with Petitioners, Plaintiff also sued an additional member of the MEC and ten professional practice groups which were allegedly owned and/or operated by certain of the Individual Defendants. These defendants were ultimately dismissed by Plaintiff. (R3-72-1; R3-75-1; R6-140-1; R7-144-1).

who formerly held privileges at the Hospital. (R1-1-¶ 2).

This suit arises out of the Hospital's decision to summarily suspend and later terminate Dr. Adkins' privileges following a series of issues concerning Dr. Adkins' professional judgment, care and treatment of two specific patients, availability, pre-admissions for surgery, completion of medical records, and attendance at meetings. (R7-149-Ex. B.8).

Dr. Adkins, in turn, sued the Healthcare Professionals under 42 U.S.C. §§ 1981, 1983, and 1985, alleging the decision to suspend and terminate his privileges was based on his race. (R1-1-¶¶ 2-3, 36).

After filing suit, Dr. Adkins served extensive discovery requests upon certain of the Healthcare Professionals, launching an attack at the heart of the medical peer review system – a system specifically designed to promote the health and safety of all patients. Specifically, Dr. Adkins' discovery requests, which totaled more than 1,100 interrogatories, including subparts, (R2-57-2 n.1; R2-57-Exs. G-K),[2]

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[2] Dr. Adkins was repeatedly warned throughout this action concerning the improper "fishing expedition" in which he appeared to be engaged. For example, in an October 20, 2004 Order, the district court noted, "It . . . appears that plaintiff's discovery request regarding peer review documents pertaining to other physicians is an overly broad fishing expedition to develop facts that *may* support a discrimination claim. This is prohibited by the Federal Rules of Civil Procedure." (R3-80-1) (emphasis in original).

Similarly, in a March 4, 2005 Order, the district court stated:

> The Court has instructed the [P]laintiff on numerous occasions . . . that his discovery requests evidence an intent

sought information on confidential peer review investigations and proceedings taking place on each and every physician at the Hospital since 1990.[3] (R2-57-Ex. G No. 13; R2-57-Ex. B Nos. 6, 10).

In view of the nature of Dr. Adkins' discovery requests, certain of the Healthcare Professionals moved for a protective order. (R2-56-1; R2-57-2). Specifically,

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> to develop facts that *may* support a discrimination claim. It has become clear that plaintiff is not aware of any other similarly situated physicians at Houston Medical Center who engaged in similar or worse misconduct but were not disciplined or terminated. Rather, the [P]laintiff appears to be using the discovery process to determine if there *may* have been other physicians who fell into this category and if he *may* have been discriminatorily suspended. These are impermissible discovery objectives, particularly when qualified immunity is applicable.

(R5-103-3) (emphasis in original).

Moreover, Dr. Adkins' own representations during the course of this litigation demonstrate his impermissible "fishing expedition." For example, in one pleading filed on his behalf in the district court, he stated, "Without first having the defendants' motion for summary judgment, and without first having the information requested in Plaintiff's motion to compel, Plaintiff is unable to articulate a discovery plan that will enable him to respond to the defendants' anticipated motion for summary judgment." (R4-101-5). Moreover, Dr. Adkins acknowledged at his deposition that he could not identify the name of any physician that was not African-American whom he believed was treated differently under similar circumstances. (R6-133-Defs' Ex. 2 at 56-57).

[3] Contrary to the Eleventh Circuit's suggestion, Dr. Adkins' peer review discovery requests were not limited to "the seven years that [Plaintiff] was a member of the hospital staff." (Pet. App. at 5a).

these Healthcare Professionals argued that, in light of this Court's decision in *Jaffee*, the states' unanimous recognition of the medical peer review privilege, and the health and safety interests furthered by the privilege, the privilege should be recognized to protect against disclosure of confidential medical peer review information pursuant to Rule 501 of the Federal Rules of Evidence, which governs when a privilege should be recognized in federal courts. (R2-57-1-19; R2-61-1-8; R3-65-1-5; R3-77-1-5). As pertinent here, Rule 501 authorizes federal courts to define new privileges in federal question cases by interpreting "principles of the common law . . . in the light of reason and experience."[4] FED. R. EVID. 501.

Following briefing and a hearing, which included participation by the Georgia Hospital Association and the Medical Association of Georgia as *amicus* in support of the Healthcare Professionals' position, the district court granted the motion for protective order. (Pet. App. 16a-21a).

In so doing, the district court recognized the "peer review process . . . serves as an integral part of the hospital's fulfillment of its duty to provide the best health care available and to ensure that any physicians who, for whatever reason, are not performing up to the hospital's expectations are subjected to a suspension of their hospital privileges." (Pet. App. 19a). The district court concluded that recognition of the medical peer review privilege is warranted under *Jaffee*, as the public's interest in promoting healthcare is served by

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[4] With respect to state law claims asserted in federal court, Rule 501 provides the applicability of a privilege "shall be determined in accordance with [s]tate law." FED. R. EVID. 501.

protecting confidential peer review information from disclosure and a consensus exists amongst the states for recognition of the privilege. (Pet. App. 19a-20a). The district court further noted that "little or no evidentiary benefit . . . . would result from the denial of the privilege in this case because the information the plaintiff seeks may very well be obtained from other sources such as through depositions of hospital administrators regarding general information about the hospital's policies and procedures for the peer review process and whether other individuals have been subjected to the same."[5] (Pet. App. 20a).

After the close of discovery,[6] the Health Care Professionals filed a motion for summary judgment, which the district court granted on May 2, 2006. (Pet. App. 22a-46a). Dr. Adkins appealed this decision, (R16-235-1), and the Eleventh Circuit reversed, declining to recognize a medical peer review privilege in "federal civil rights" or "federal discrimination cases" and concluding the "district court improperly limited the scope of discovery and, as a result, prematurely granted Defendants' motion for summary judgment." (Pet. App. 3a).

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[5] Notably, Dr. Adkins never took any of the depositions suggested by the district court.

[6] Although the district court initially determined that Dr. Adkins was precluded from any peer review discovery, it later ordered that Dr. Adkins be provided peer review information concerning himself and members of the Hospital's Department of Surgery (the department in which Dr. Adkins practiced) for the five years preceding the termination of Dr. Adkins' privileges, in the form of descriptions but not the peer review documents themselves. (R5-103-4-10; R5-109-2, 6). This information was produced to Dr. Adkins. (R7-185-1).

In reaching its decision, the Eleventh Circuit acknowledged the medical peer review privilege "serve[s] important interests" and "promote[s] vigorous oversight of physician performance." (Pet. App. 8a). The Eleventh Circuit nevertheless concluded the "interest of furthering discovery of probative and relevant evidence to root out invidious discrimination" outweighed "the interests to be derived from recognizing the privilege" and that "[t]he only way that [Dr.] Adkins can demonstrate the existence of disparate treatment in his case against the hospital is to compare his peer review files with the peer review files of other physician at [the hospital]." (Pet. App. 9a, 11a-12a).

The Healthcare Professionals filed a timely petition for rehearing *en banc*, which the full Eleventh Circuit denied on August 16, 2007. (Pet. App. at 48a-49a).

REASONS FOR GRANTING THE PETITION

A. The Eleventh Circuit's Decision Conflicts With This Court's Precedent

The Eleventh Circuit framed the issue before it as being whether to recognize the medical peer review privilege in "federal civil rights cases" or "federal discrimination cases." (Pet. App. 3a). In refusing to recognize the medical peer review privilege in this context, the Eleventh Circuit concluded the "interest of furthering discovery of probative and relevant evidence to root out invidious discrimination" outweighed "the interests to be derived from recognizing the privilege" and that "[t]he only way that [Dr.] Adkins can demonstrate the existence of disparate treatment in his case against the hospital is to compare his peer review

files with the peer review files of other physician at [the hospital]." (Pet. App. 9a, 11a-12a). The Eleventh Circuit's analysis is directly contrary to *Jaffee*, this Court's most recent decision analyzing when a new privilege should be recognized under Federal Rule of Evidence 501.

Specifically, in *Jaffee*, this Court determined the psychotherapist-patient privilege should be recognized as a matter of federal common law. In so doing, the Court expressly rejected the Seventh Circuit's analysis, which was the same analysis engaged by the Eleventh Circuit here – a balancing of the evidentiary need in a particular case against the broad benefit derived from the privilege. In particular, in recognizing the existence of the psychotherapist-patient privilege under Federal Rule of Evidence 501, the Seventh Circuit "qualified its recognition of the privilege by stating that it would not apply if in the interests of justice, the evidentiary need for the disclosure of the contents of a patient's counseling outweighs the patient's privacy interests." *Id.* at 7 (internal citation and quotations omitted). This Court, however, squarely rejected this reasoning and explained that recognition of a privilege does *not* depend upon the circumstances under which the claim is asserted:

> We part company with the Court of Appeals on a separate point. We reject the balancing component of the privilege implemented by that court and a small number of States. Making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the

> privilege. . . . [I]f the purpose of the privilege is to be served, the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying application by the courts, is little better than no privilege at all.

Id. at 17-18 (internal quotations and citation omitted); *see also Koch v. Cox*, 489 F.3d 384, 388-89 (D.C. Cir. 2007) ("The Court [in *Jaffee*] squarely rejected the position that a court should balance the need for relevant information in the particular case before it against the invasion of a patient's privacy."); *Nilavar*, 210 F.R.D. at 606 ("[A] privilege should either be recognized in the common law, or it should not. Its application should not turn on whether . . . the claim, which appears later in time to the occurrence of the so-called confidential communication, is one arising under malpractice law, discrimination law, or antitrust law.").

Thus, pursuant to *Jaffee*, the existence of a medical peer review privilege cannot depend upon whether the case in which the material is sought involves a claim of discrimination, as the Eleventh Circuit determined. In *Jaffee*, this Court instructed federal courts to engage in a much broader analysis, determining whether a privilege *generally* "promotes sufficiently important interests to outweigh the need for probative evidence." 518 U.S. at 9-10 (internal quotations and citation omitted). This balancing must take into account both the competing benefits and the resulting effects of recognizing (or eradicating) the privilege in its entirety, not in a particular subset of cases.

Jaffee indicates there is no basis to carve out an exception based on the potential impact on a plaintiff's ability to prove his or her case. *See id.* at 17-18. Indeed, important privileges – such as the attorney-client and therapist-patient privileges – will often apply to bar discovery of crucial evidence. The issue is whether the social interests promoted by recognition of a privilege justify permitting evidentiary restrictions that may, in certain situations, be onerous. Given the peer review privilege's obvious and critical benefits to society to enhance and ensure quality medical care and the consensus of the states for recognition of the privilege, the medical peer review privilege should be recognized in this case. *See Jaffee*, 518 U.S. at 13 ("the existence of a consensus among the States indicates that `reason and experience' support the recognition of the privilege").

Moreover, while *Jaffee* does instruct courts to look at the likely evidentiary benefit that would result from the denial of the privilege, the test articulated in *Jaffee* is a "forward looking test": what evidence would there be if everyone knew from the outset that the communications would not be privileged.

In regard to the psychotherapist-patient privilege, this Court noted that "[w]ithout [that] privilege, much of the desirable evidence . . . is unlikely to come into being. This unspoken `evidence' will serve no greater truth-seeking function than if it had been spoken and privileged." *Id.* at 13.

And the same holds true with respect to the peer review privilege. As noted, the Healthcare Professionals produced evidence in this case which showed that with the abrogation of the peer review privilege at Sumter, doctors have dramatically reduced their participation in peer review proceedings. (R1-61-

Ex. A at ¶ 6). Thus, as shown by what has transpired at Sumter, little evidentiary benefit can be derived by rejecting the medical peer review privilege, as physicians will no longer participate on peer review committees.

In addition, the Eleventh Circuit's refusal to recognize the peer review privilege in this case opens pandora's box as to the types of claims for which a plaintiff can now get access to peer review information. Indeed, in light of *Jaffee*, the Eleventh Circuit's decision cannot be read as simply limiting the discovery of peer review information to discrimination or civil rights cases. This is particularly true, given that one of the cases upon which the Eleventh Circuit principally relied – *Mem'l Hosp. v. Shadur*, 664 F.2d 1058, 1059 (7th Cir. 1981) (per curiam) – is not a civil rights case, but an antitrust case.

Thus, in view of the Eleventh Circuit's decision, any plaintiff – whether a physician, patient, prisoner, or general citizen – can wreak havoc on a hospital or other healthcare entity by baldly asserting a federal claim against it – whether it be a discrimination, antitrust, deliberate indifference, or EMTALA claim – and then seeking discovery of the hospital's peer review files without limitation, as Dr. Adkins did here. Such a result invites plaintiffs to file meritless litigation against hospitals in the hope of coercing settlement and should not be allowed. *Cf. Bell Atlantic Corp. v. Twombly*, 127 S. Ct. 1955, 1967 (2007) ("the threat of discovery expense will push cost-conscious defendants to settle even anemic cases").

Along with being contrary to *Jaffee*, the Eleventh Circuit's view that a plaintiff is entitled unfettered access to all peer review materials during his tenure at a hospital because "[t]he only way that [a

plaintiff] can demonstrate the existence of disparate treatment in his case against the hospital is to compare his peer review with the peer review files of other physicians at [the hospital]," (Pet. App. 9a), fails to recognize the realities of litigation.

Indeed, provided a viable claim exists, a plaintiff-physician has other means to prove a discrimination claim against a hospital or other healthcare professional aside from obtaining privileged and confidential peer review materials. For example, a plaintiff-physician could depose other physicians within his or her department[7] and ask them if they had ever engaged in conduct similar to that of the plaintiff, but received no adverse action. Similarly, a plaintiff-physician could depose his or her patients and/or their family members or medical personnel present during the procedures giving rise to the adverse action, and ask them what happened in the course of plaintiff's care and treatment and about any discussions these persons may have had with hospital personnel. Moreover, a plaintiff-physician could depose hospital administrators and ask them about how the peer review process is supposed to work at the hospital in general in attempt to show he was not treated the same as others, as the district suggested to Dr. Adkins. (Pet. App. 20a). In this action, Dr. Adkins chose to do none of these things, and the Eleventh Circuit rewarded his decision to do nothing to prosecute his claims.[8]

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[7] Under Georgia law, documents obtainable from original sources are not protected by the peer review privilege. *See McCall v. Henry Med. Ctr.*, 551 S.E.2d 739, 744 (Ga. App. 2001).

[8] Despite a lengthy discovery period spanning more than eight months, Dr. Adkins only deposed three people – only two being named Defendants (Dr. Deighton and Dr. Kazi). Moreover, Dr.

Given the important issue at stake, the consensus among the states to recognize a medical peer review privilege, and the conflict between the Eleventh Circuit's decision and this Court's precedent, the Healthcare Professionals respectfully maintain that certiorari is warranted.

B. The Eleventh Circuit's Decision Presents A Conflict In Approach With The Fifth Circuit And Sharpens The Current Disarray Regarding The Medical Peer Review Privilege

1. The Eleventh Circuit's Decision Conflicts In Approach With the Fifth Circuit

In *United States v. Harris Methodist Ft. Worth*, 970 F.2d 94 (5th Cir. 1992), the Fifth Circuit considered whether the government's investigation under Title VI into alleged discrimination by a hospital satisfied the Fourth Amendment's "reasonableness" requirement. The Fifth Circuit balanced "two important competing public interests": "preventing discrimination against minority health care professionals" and "the confidentiality of peer review, a process critical to the advancement of quality health care." *Id.* at 101. The Fifth Circuit recognized "an overwhelming public

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Adkins never deposed (1) any member of his department (the Department of Surgery) other than Dr. Deighton; (2) any administrator or 30(b)(6) representative of the Hospital; or (3) any original source (e.g. the patients and/or their family members, medical personnel present during the procedures performed by Dr. Adkins, and physicians in the Department of Surgery).

interest in promoting improvement in health care through the mechanism of [physician] peer review" and held that any investigation was required to protect the confidentiality of medical peer review. *Id.* (internal quotations and citation omitted).

The Fifth Circuit expressly considered the hospital's claim "that the physician peer review materials sought in the compliance review are subject to privilege." *Id.* at 103. The Court recognized Congress' findings that "peer review materials are sensitive and inherently confidential, and protecting that confidentiality serves an important public interest." *Id.* (citing 42 U.S.C. §§ 11101(5), 11137(b)). The Fifth Circuit held that the government's investigation under Title VI could not "override" those important goals. *Harris Methodist Ft. Worth*, 970 F.2d at 103. The Fifth Circuit distinguished this Court's holding in *University of Pennsylvania v. EEOC*, which had refused to endorse a privilege for academic peer review, on the ground that "the medical peer review process is a *sine qua non* of adequate hospital care." *Id.* (internal citation and quotations omitted).

The Eleventh Circuit's decision below cannot be squared with the Fifth Circuit's approval of a medical peer review privilege. The Eleventh Circuit undertook virtually the exact same balancing as the Fifth Circuit – the interest in preventing discrimination against the need to protect the integrity of the peer review process. (Pet. App. 8a-9a). In conducting that balancing, the Eleventh Circuit held that discovery of evidence to determine whether there has been discrimination is an "overriding goal" that prohibits any application of a privilege. (Pet. App. 9a). The Fifth Circuit by contrast conducted the same balancing and held that the "important public interest" in protecting

the confidentiality of medical peer review is an "overrid[ing]" goal that supports the existence of a privilege. *Harris Methodist Ft. Worth*, 970 F.2d at 103.

Although the Fifth Circuit in *Harris Methodist Ft. Worth* declined to "define the scope" of any medical peer review privilege, its opinion clearly evidences a conflict in approach with the Eleventh Circuit. This Court in *University of Pennsylvania v. EEOC* granted review based only on "what might be thought of as a conflict in approach" with another circuit, because of "the importance of the issue." 493 U.S. at 188. Protecting medical peer review – "a process critical to the advancement of quality health care," *Harris Methodist Ft. Worth*, 970 F.2d at 101 – is unquestionably an even more important issue than preserving the sanctity of academic tenure decisions, and the "conflict in approach" between the Fifth and Eleventh Circuits as at least as strong as the split in *University of Pennsylvania*.

2. The Eleventh Circuit's Decision Sharpens The Current Disarray Regarding The Medical Peer Review Privilege

Lower federal courts are currently in disarray over whether to recognize the medical peer review privilege. Every state recognizes the privilege, and federal courts are struggling to reconcile this Court's decisions in *University of Pennsylvania* and *Jaffee*.

In *University of Pennsylvania*, this Court declined to recognize a privilege for academic peer review of tenure decisions on the ground that such privilege "has no . . . historical or statutory basis." 493 U.S. at 195. In so doing, the Court appeared to engage in a balancing test, weighing the need to protect the

confidentiality of academic peer review communications against the value of the disclosure in the particular case. Specifically, the Court noted:

> We readily agree with petitioner that universities and colleges play significant roles in American society. Nor need we question, at this point, petitioners' assertion that confidentiality is important to the proper functioning of the peer review process under which many academic institutions operate. The costs that ensue from disclosure, however, constitute only one side of the balance. As Congress has recognized, the costs associated with racial and sexual discrimination in institutions of higher learning are very substantial. Few would deny that ferreting out this kind of invidious discrimination is a great, if not compelling, governmental interest. Often, . . . disclosure of peer review materials will be necessary in order for the [EEOC] to determine whether the illegal discrimination has taken place. Indeed, if there is a `smoking gun' to be found that demonstrates discrimination in tenure decisions, it is likely to be tucked away in peer review files.

Id. at 193.

This Court in *Jaffee*, in contrast, recognized a psychotherapist-patient privilege despite a lack of common law history or statutory guidance on the ground that such a privilege was essential for confidence and trust, served important public ends, and was consistent with state rules. 518 U.S. at 10-13. Furthermore, in apparent conflict with *University of Pennsylvania*, this Court in *Jaffee* expressly rejected a

balancing test of weighing the value of confidentiality against the value of disclosure in a particular case. *Id.* at 17 ("Making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege.").

Notably, the Eleventh Circuit along with the other Courts of Appeals' decisions it relied upon to reject the medical peer review privilege applied the balancing apparently approved by *University of Pennsylvania*, but rejected in *Jaffee*. (Pet. App. at 9a); *Virmani v. Novant Health Inc.*, 259 F.3d 284, 289 (4th Cir. 2001) ("We agree with [the hospital] that the privilege it seeks would serve important interests. However, as is the case in the academic context, the evidentiary benefit that will be refusing to grant a privilege for medical peer review materials in a discrimination case is potentially great. The evidence that [the plaintiff-physician] seeks is crucial to his attempt to establish that he has been the subject of disparate treatment on the basis of race and ethnicity."); *Mem'l Hosp. v. Shadur*, 664 F.2d 1058, 1061-62 (7th Cir. 1981) (per curiam) ("[I]n deciding whether the privilege asserted should be recognized, it is important to take into account the particular factual circumstances of the case in which the issue arises. . . . [T]he need for full disclosure of relevant evidence to the trier of fact, while always substantial, is particularly so in this case.").[9]

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[9] Although decided nine years earlier, *Mem'l Hosp.* applied the same balancing apparently approved by *University of Pennsylvania*.

In contrast, the federal district courts that have recognized the medical peer review privilege have engaged in an analysis consistent with *Jaffee*. (Pet. App at 17a-20a); *Hadix v. Caruso*, 2006 U.S. Dist. LEXIS 72967 (W.D. Mich. Oct. 6, 2006) (recognizing privilege in prisoner civil rights case); *Weekoty*, 30 F. Supp. 2d at 1347-48 (recognizing privilege as a matter of federal common law under Federal Rule of Evidence 501); *Cohn v. Wilkes Gen'l Hosp.*, 127 F.R.D. 117, 121 (W.D.N.C. 1989) (recognizing peer review privilege in federal antitrust action); *cf. Nilavar*, 210 F.R.D. at 607 ("If *Jaffee* were the only source of authority for the Court's decision in this case, Defendants' argument that a physician peer review privilege should be recognized would pose a close question indeed.").

Aside from engaging in the balancing rejected by *Jaffee*, the lower federal courts reliance on *University of Pennsylvania* to deny a medical peer review privilege is wrong. Indeed, a peer review privilege in the academic context is distinguishable from one in the medical context. *See Hadix*, 2006 U.S. Dist. LEXIS 72967, at *5 ("Many of the decisions which have followed the *University of Pennsylvania* decision have applied it overly broadly to contexts which were not intended by the Supreme Court and which belie the intent of Rule 501 (to allow a flexible approach to the federal common law of privilege which serves important national interests).").

Specifically, while denying an academic peer review privilege may reduce freedom in tenure decisions, denying the medical peer review privilege has the more detrimental effect of sacrificing adequate health care. *See Harris Methodist Ft. Worth*, 970 F.2d at 103 ("[U]nlike the privilege claim for faculty tenure decisions . . . the medical peer review process is *sine*

qua non of adequate hospital care.") (internal quotations and citations omitted). Moreover, "[m]edical peer review, unlike academic peer review, is variously protected by the laws of all 50 states, which shield peer review documents from civil discovery." *Hadix*, 2006 U.S. Dist. LEXIS 72967, at *6.

Furthermore, the rejection of the academic peer review privilege in *University of Pennsylvania* was based on the specific circumstances of that case. Specifically, *University of Pennsylvania* arose out of the EEOC's investigation of a Title VII charge of discrimination. In particular, following the filing of a charge, the EEOC issued a subpoena to the University of Pennsylvania seeking, among other things, certain tenure files relating to the charging party's claim. *See University of Pennsylvania*, 493 U.S. at 186. In response, the University opposed the subpoena, arguing, among other things, a common law qualified privilege against disclosure of academic peer review files should be recognized. *Id.* at 188.

In refusing to recognize the privilege, the Court based its decision on the fact that Title VII expressly provides that the EEOC is entitled to broad access to relevant evidence, subject only to a confidentiality requirement. *Id.* at 192-93. Thus, this Court reasoned that Congress had already decided the issue: it gave the EEOC the right under Title VII to obtain all evidence relevant to the charge under investigation. As such, the Court concluded that recognizing an academic peer review privilege in this context would be inconsistent with Congress' directives. *See id.* at 189 ("We are especially reluctant to recognize a privilege in an area where it appears that Congress has consider the relevant competing concerns but has not provided the privilege itself.'); *id.* at 194 ("[W]e stand behind the

breakwater Congress has established: unless specifically provided otherwise in the statute, the EEOC may obtain `relevant' evidence. Congress has made the choice. If it dislikes the result, it of course may revise the statute.").

The circumstances of this case are completely different than in *University of Pennsylvania*, as it involves neither a claim under Title VII nor the EEOC's efforts to obtain peer review information.[10] Indeed, unlike in *University of Pennsylvania*, there is simply no statute requiring the Healthcare Professionals to produce the medical peer review information as sought by Dr. Adkins.[11]

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[10] Notably, Dr. Adkins specifically elected to bypass Title VII and, instead, proceeded with his claims under 42 U.S.C. §§ 1981, 1983, and 1985.

[11] The Health Care Quality Improvement Act ("HCQIA") in no way supports abrogation of the peer review privilege. While the Act does not confer immunity from civil rights claims that does not mean it eliminated the privileges afforded to peer review committees. Indeed, this very issue was addressed by Representative Waxman, the main sponsor of the House Bill:

> The basic point to be made is that the courts should not read anything in this bill as authorizing the overriding of any State and Federal law relating to discovery. Specifically, I understand that there are a number of State shield laws that restrict the type of evidence that may be introduced in lawsuits challenging a disciplinary action in the context of peer review. Nothing in this bill is intended to preempt or override any such State shield law.

132 Cong. Rec. 33,177; *see also Virmani*, 259 F.3d at 291 ("we *cannot* conclude that Congress actually considered and rejected a privilege for medical review materials when enacting the HCQIA") (emphasis added).

Given the inconsistencies between *University of Pennsylvania* and *Jaffee*, the consensus amongst the states to recognize a medical peer review privilege, and the disarray in the lower federal courts regarding whether to recognize the privilege, certiorari is warranted.

C. This Court Should Grant Review Now To Prevent Serious Harm To Patients And The Medical System

There is no question that had this suit been filed in state court, Dr. Adkins would not be entitled to any medical peer review discovery. Indeed, contrary to the Eleventh Circuit suggestion, (Pet. App. 11a), the Georgia peer review privilege is not limited to situations involving medical malpractice; rather, it also applies to actions brought by physicians challenging the peer review process itself. *See Patton*, 539 S.E.2d 529-30; *Doe v. Unum Life Ins. Co. of Am.*, 891 F. Supp. 607, 610 (N.D. Ga. 1995) ("[T]he peer review statutes confer upon peer review organizations the qualities of a black hole."); *see also Kingsley v. Sachitam*, 783 So.2d 824, 826 (Ala. 2000) (rejecting disclosure of peer review documents in physician's action challenging negligence in performance of peer review); *Dworkin v. St. Francis Hosp., Inc.*, 517 A.2d 302, 307 (Del. Super. 1986) (medical peer review privilege applied in suit for wrongful termination of medical privileges); *Holly v. Auld*, 450 So.2d 217, 221 (Fla. 1984) (holding medical peer review discovery privilege is not limited to medical malpractice action and applies in defamation action); *Frank v. Trustees of Orange County Hosp.*, 530 N.E.2d 135, 137-38 (Ind. App. 1st Dist. 1988) (peer review information not subject to discovery in breach of

contract case brought by physician against hospital); *Doe v. Grant*, 839 So.2d 408, 416-17 (La. App. 4th Cir. 2003) (statements made during peer review meeting were protected under peer review statute in defamation and breach of contract suit brought by doctor against hospital and members of peer review committee); *St. Joseph Med. Ctr., Inc. v. Cardiac Surgery Assocs., P.A.*, 896 A.2d 304, 315-18 (Md. 2006) (peer review records protected from disclosure in unfair competition and tortious interference action); *Amaral v. Saint Cloud Hosp.*, 598 N.W.2d 379, 388 (Minn. 1999) (upholding peer review privilege from disclosure in non-medical malpractice action); *Soentgen v. Quain & Ramstad Clinic, P.C.*, 467 N.W.2d 73, 79-80 (N.D. 1991) (peer review statements were privileged in defamation and wrongful discharge suit); *Wall v. Ohio Permanente Med. Grp., Inc.* 695 N.E.2d 1233, 1238-40 (Ohio App. 1997) (finding doctor not entitled to discovery of peer review information in wrongful discharge action); *Straube v. Larson*, 600 P.2d 371, 374-76 (Or. 1979) (peer review information protected from disclosure in suit against hospital for suspending a doctor's privileges); *Irving Healthcare Sys. v. Brooks*, 927 S.W.2d 12, 20-22 (Tex. 1996) (documents and communications relating to proceedings of peer review committee are not discoverable in suit for damages when doctor claims communications to committee were made with malice); *Ragland v. Lawless*, 812 P.2d 872, 867-77 (Wash. App. 1991) (peer review records immune from discovery in suit by physician against medical society and chairmen of peer review committee).

This Court should not wait for further disagreements among the lower federal courts to resolve the critical issue of the discoverability of medical peer review information in federal cases, as the

Eleventh Circuit's abrogation of the privilege places patient care in jeopardy. Every state has carefully considered the importance of revealing medical peer review information against the importance of protecting its confidentiality, and every state has ended up in favor of recognizing a medical peer review privilege.

Under *Jaffee*, "the existence of a consensus among the States indicates that 'reason and experience' support the recognition of the privilege." 518 U.S. at 13. Furthermore, this Court has held that "general healthcare regulation . . . historically has been a matter of local concern." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651 (1995) (citation omitted). It is, therefore, particularly appropriate for federal courts to defer to the states' judgment in recognizing a medical peer review privilege. *See Jaffee*, 518 U.S. at 13 ("Denial of the federal privilege . . . would frustrate the purposes of the state legislation that was enacted to foster these confidential communications.").

This case presents an excellent vehicle through which to provide guidance to the lower federal courts. The issue is squarely presented, is outcome determinative, and is ripe for this Court's review.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request that their petition for a writ of certiorari be granted.

Respectfully submitted,
PAUL R. KOSTER*
Counsel of Record

CYNTHIA MATTHEWS DALEY
DALEY, KOSTER & LAVALLEE, LLC
OVERLOOK I
2849 PACES FERRY ROAD
ATLANTA, GA 30339
(678) 213-2401

RUSH S. SMITH, JR.
HALL, BOOTH, SMITH & SLOVER, P.C.
1180 WEST PEACHTREE STREET
SUITE 900
ATLANTA, GA 30309
(404) 954-5000

Attorneys for Petitioners

(any footnotes trail end of each document)

No. 06-13107
UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

RUSSELL E. ADKINS, MD,
Plaintiff-Appellant,

Versus

ARTHUR P. CHRISTIE, Individually, and in his Official Capacity as the Administrator of Houston Medical Center, ANTHONY L. ALFORD, Individually and in his Official Capacity as Executive Director for Medical Affairs of Houston Medical Center, DANIEL A. DEIGHTON, Individually and in his Official Capacity as Chief of Staff and in his Official Capacity as a Member of the Medical Executive Committee at Houston Medical Center, FREDERICK W. JENNART, Individually and in his Official Capacity as a Member of the Medical Executive Committe at Houston Medical Center, DAVID N. HARVEY, MD, Individually, and in his Official Capacity as a Member of the Medical Executive Committee at Houston Medical Center, et al.,
Defendants-Appellees.

June 12, 2007, Decided

June 12, 2007, Filed

COUNSEL: For Adkins, Russell E., Appellant: Crucilla, Bernadette, Buafo & Associates, MACON, GA.

For Appellant: Buafo, Althea L., Buafo & Buafo & Associates, MACON, GA.

For Christie, Arthur P., Appellee: Koster, Paul Robert, Daley, Koster and LaVallee, LLC, ATLANTA, GA.

For Alford, Anthony L., Deighton, Daniel A., Jennart, Frederick W., Harvey, David N., Appellees: Daley, Cynthia M., Daley, Koster & LaVallee, LLC, ATLANTA, GA.

For Appellee: Smith, Rush S. Jr., Hall, Booth, Smith & Slover, PC, ATLANTA, GA.

For Georgia Hospital Association, Amicus: Grady, Kevin E., Alston & Bird, ATLANTA, GA.

For The Medical Association of Georgia, Amicus: Looby, Brian William, Medical Association of Georgia, ATLANTA, GA.

For Amicus: Smith, Jack Palmer III, Alston & Bird LLP, ATLANTA, GA.

JUDGES: Before EDMONDSON, Chief Judge, BIRCH and WILSON, Circuit Judges.

OPINION BY: WILSON

OPINION

WILSON, Circuit Judge:

This appeal concerns an evidentiary privilege known as the "medical peer review privilege." The privilege seeks

to protect from discovery and disclosure records containing performance reviews and assessments of physicians by their peers, primarily in connection with their practice at hospitals. The issue before us is whether to recognize the privilege in federal civil rights cases. The Fourth and Seventh Circuits have denied the privilege in these cases. We join them in declining to recognize a privilege for documents relating to medical peer review proceedings in federal discrimination cases.

We also conclude in this opinion that the district court improperly limited the scope of discovery and, as a result, prematurely granted Defendants' motion for summary judgment.

Background

These issues arose in Dr. Russell Adkins' federal civil rights action, filed pursuant to 42 U.S.C. §§ 1983, 1981 and 1985. In his complaint, Adkins, an African-American staff physician with privileges at the Houston Medical Center ("HMC"), asserted that HMC and several HMC physicians (collectively "Defendants") discriminated against him on racial grounds in their implementation and utilization of HMC's peer review and physician disciplinary process. In conformity with Medical Staff Bylaws, Adkins was provisionally admitted to practice at HMC in 1997 for a minimum of one year. Adkins contends that during this first year, the head of the Department of Surgery, Dr. Deighton, unilaterally chose to review all of Adkins' medical charts, an unusually high level of review for new physicians. None of Adkins' cases during his first year were found to warrant further investigation by a peer

review committee. Nevertheless, HMC extended his provisional status by six months on the grounds that he allegedly failed to follow protocols for pre-admission of surgical patients, failed to complete medical records in a timely manner and had problems with availability for call. Adkins concedes that he failed to complete medical charts within the time frame dictated by HMC's Medical By-laws on eight different occasions during that time. However, he argues that such delays were a hospital-wide problem and that Deighton himself acknowledged having received warning letters for failure to complete his charts in a timely manner.

Adkins further claims that in 2001, and again in 2002, HMC imposed additional conditions on his continued employment even though he had a good record as a physician. Finally, Adkins claims that HMC deliberately mishandled the care of one of his patients, S.K., and later used that case as a pretext to take action against him. Specifically, he alleges that nurses falsified reports related to S.K.'s condition, refused to contact him about her care, and contravened his orders relating to her care, resulting in her pain and discomfort. He claims that the staff at HMC incorrectly informed S.K. that he was out of town, and deliberately withheld information about her status from him, which ensured that he was unavailable to assist her. He argues that HMC then used S.K.'s case as grounds to begin peer review of his practices, and unfairly determined that he was unavailable to assist S.K., meting out the disproportionately harsh penalties of suspension and subsequently, termination against him.

Defendants dispute this characterization of Adkins' practice at the hospital. They allege that Adkins

repeatedly experienced problems with availability for call, timely completion of medical records and failure to follow hospital protocol on patient admissions. Defendants further allege that in 2002, Adkins grossly mishandled a surgical operation on a seven-month-old infant by operating on him without proper surgical equipment, thus raising additional questions about his professional judgment. Finally, Defendants allege that peer review of Adkins' treatment of S.K. was automatically required by hospital procedure that mandated review of all patient cases involving repeat surgeries. They claim that external peer review determined that Adkins' availability and level of care was inadequate, and that in light of his record, suspension was an appropriate measure to protect the health and safety of patients at the hospital.

In May 2004, Defendants sought dismissal of Adkins' complaint for failure to state a claim on qualified immunity grounds. The district court converted this motion into one for summary judgment and initially allowed discovery on issues relating to qualified immunity only. During discovery, Adkins requested documents relating to peer review of *all* physicians at the hospital during the seven years that Adkins was a member of the hospital staff. In response, Defendants filed a motion for a protective order, arguing that Adkins was seeking information relating to the peer review process, which was covered by the Georgia medical peer review privilege.[1] Although the court concluded that the privilege applied to federal civil rights actions, it nevertheless ordered Defendants to provide Adkins with descriptions of all incidents giving rise to peer review, without disclosing the documents themselves. The court limited production to peer

review documents covering physicians it deemed similarly situated to Adkins, namely physicians in the Department of Surgery during a five-year time period, rather than documents relating to all physicians with staff privileges at HMC during the seven-year time period requested by Adkins.

In response to Defendants' motion for summary judgment, the district court undertook in-camera review of the disclosed peer review files. The court also reviewed a list identifying the race of the forty-seven physicians at HMC that were suspended in the last five years. Following this review, the court granted summary judgment in favor of Defendants. Adkins now appeals the judgment, contending that the court improperly recognized the privilege, and improperly limited the scope of his discovery request.

The Medical Peer Review Privilege

Adkins argues that the district court incorrectly ruled that federal law allows for a medical peer review privilege in discrimination cases. The decision to recognize a privilege is a mixed question of law and fact, which we review *de novo.* Fed. R. Evid. 501; *Carman v. McDonnell Douglas Corp.*, 114 F.3d 790, 793 n.2 (8th Cir.1997). While all fifty states and the District of Columbia recognize such a privilege, the Eleventh Circuit has not yet definitively ruled on whether it applies in federal court, and as we previously stated, the Fourth and Seventh Circuits have failed to recognize the privilege. *See Virmani v. Novant Health, Inc.*, 259 F.3d 284, 289 (4th Cir. 2001); *Mem'l Hosp. v. Shadur*, 664 F.2d 1058, 1063 (7th Cir. 1981) (per curiam).

Evidentiary privileges in the federal courts are governed by Fed. R. Evid. 501, which provides:

Except as otherwise required by the Constitution . . . as provided by Act of Congress, or in rules prescribed by the Supreme Court . . ., the privilege of a witness . . . shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience.Fed. R. Evid. 501.

The Federal Rules of Evidence empower the federal courts to "continue the evolutionary development of [evidentiary] privileges." *Trammel v. United States*, 445 U.S. 40, 47, 100 S. Ct. 906, 910, 63 L. Ed. 2d 186 (1980). However, these privileges remain disfavored and should not be lightly created. *United States v. Nixon*, 418 U.S. 683, 710, 94 S. Ct. 3090, 3108, 41 L. Ed. 2d 1039 (1974). The Supreme Court has cautioned that privileges "contravene the fundamental principle that the public . . . has a right to every man's evidence." *Univ. of Pa. v. EEOC*, 493 U.S. 182, 189, 110 S. Ct. 577, 582, 107 L. Ed. 2d 571 (1990) (alteration in original) (internal quotation marks omitted). Accordingly, there is a presumption against privileges which may only be overcome when it would achieve a "public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth." *Trammel*, 445 U.S. at 50, 100 S. Ct. at 912. This is a high standard, and "only the most compelling candidates will overcome the law's weighty dependence on the availability of relevant evidence." *Pearson v. Miller*, 211 F.3d 57, 67 (3d Cir. 2000).

The Supreme Court's decision in *Jaffee v. Redmond*, 518 U.S. 1, 116 S. Ct. 1923, 135 L. Ed. 2d 337 (1996), provides us with useful guidance on how to determine whether an evidentiary privilege should be created. In *Jaffee*, the Supreme Court identified some factors as relevant to the inquiry including: 1) the needs of the public good; 2) whether the privilege is rooted in the imperative need for confidence and trust; 3) the evidentiary benefit of the denial of the privilege; and 4) consensus among the states. 518 U.S. at 10-16, 116 S. Ct. at 1928-31. In deciding whether to recognize a privilege, we must consider that there is "a general duty to give what testimony one is capable of giving, and that any exemptions which may exist are distinctly exceptional, being so many derogations from a positive general rule." *Id.* at 9, 116 S. Ct. at 1928.

Defendants, joined by amicus curiae the Georgia Hospital Association, primarily rely on the needs of the "public good" to support their argument for recognizing a medical peer review privilege. They contend that the absence of the privilege would chill supervising physicians, making them less candid in their performance evaluations of staff physicians for fear that their assessments and statements might be used for improper purposes. For example, they contend that peer review materials might be used to generate medical malpractice litigation. They raise concerns about patient confidentiality. They argue that the quality of the oversight process, and thus of healthcare itself, would suffer if the privilege is not recognized.

We agree with HMC that the privilege it seeks would serve important interests. The privilege would promote vigorous oversight of physician performance. But the

privilege must be considered against a corresponding and overriding goal -- the discovery of evidence essential to determining whether there has been discrimination in employment. Guided by the principles disfavoring privileges, as well as the *Jaffee* factors, we conclude that the medical peer review process does not warrant the extraordinary protection of an evidentiary privilege in federal civil rights cases. Here, we are confronted with a claim of racial discrimination within the peer review process itself, implicating the important social goal of eliminating employment discrimination. *See, e.g., Univ. of Pa.*, 493 U.S. at 193, 110 S. Ct. at 584 (finding that exposing "invidious discrimination is a great, if not compelling governmental interest").

Further, the documents that HMC seeks to protect are critical to Adkins' discrimination claims. The only way that Adkins can demonstrate the existence of disparate treatment in his case against the hospital is to compare his peer review with the peer review files of other physicians at HMC. In *Shadur*, the Seventh Circuit was similarly confronted with a situation where recognizing a medical peer review privilege would effectively bar a plaintiff's claim. *Shadur*, 664 F.2d at 1062-63. In that federal antitrust action, Plaintiff sought medical peer review materials in order to demonstrate that the Defendant physicians used the review process discriminatorily in furtherance of a conspiracy to destroy his practice and thus limit competition. *Id* at 1063. Taking into account the compelling public policy favoring such antitrust actions, the court found that the privilege should not be recognized when it would prevent the plaintiff from asserting his claim altogether. *Id.* In *Virmani*, the Fourth Circuit was

similarly guided by the evidentiary benefit presented by peer review documents in employment discrimination cases. 259 F.3d at 289. Confronted with a claim virtually identical to the one at hand, the court found that "[t]he interest in facilitating the eradication of discrimination by providing perhaps the only evidence that can establish its occurrence outweighs the interest in promoting candor in the medical peer review process." *Id.*

We recognize that health care providers, like HMC and its supervising physicians, have a legitimate interest in keeping peer review documents confidential and in protecting them from widespread dissemination. However, "[t]here is an important distinction between privilege and protection of documents, [with] the former operating to shield the documents from production in the first instance, [and] the latter operating to preserve confidentiality when produced." *Id.* at 288 n.4. In the absence of the privilege, the district court retains its authority to protect HMC's interests through other established means such as protective orders, confidentiality agreements, and when appropriate, by disclosure only after an in-camera review of these documents. *See, e.g., Kerr v. United States District Court*, 426 U.S. 394, 405, 96 S. Ct. 2119, 2125, 45 L. Ed. 2d 725 (1976) (noting that methods such as in-camera review of documents can be used to balance a party's need for confidentiality against an adverse party's need for evidence);*Marrese v. American Acad. of Orthopaedic Surgeons*, 726 F.2d 1150, 1160 (7th Cir. 1984) (*en banc*) (noting that there are different ways for district courts to protect non-privileged documents) *rev'd on other grounds*, 470 U.S. 373, 105 S. Ct. 1327, 84 L. Ed. 2d 274 (1984). The district

courts are well-equipped with a variety of mechanisms to ensure that peer review materials, once furnished through discovery, are not compromised by wayward hands, i.e., redaction of extraneous or confidential information, in-camera review and protective orders. The "public good" concerns advanced by the defendants may capably be served in the absence of a medical peer review privilege.

We are mindful of the fact that a medical peer review privilege is recognized by all fifty states and the District of Columbia, a factor that *Jaffee* lists in Defendants' favor. The Fourth Circuit addressed this argument in *Virmani*, and rejected that factor on the grounds that there is a strong evidentiary benefit to be obtained in a discrimination case, and that the state statutes address different policy concerns when they balance the need for candor in peer review discussions against a plaintiff's access to evidence in a malpractice suit. 259 F.3d at 290-91. The interests at issue in a discrimination claim like this one are different from that of a malpractice case, and merit a different analysis. As the *Virmani* court correctly observed, "[t]here is no evidence that state legislatures considered the potential impact on discrimination cases of a privilege for medical peer review proceedings." *Id.* at 291. We agree that "the states' policy decisions, reflecting different concerns than those implicated here, [should] not inform the judgment of the court in this case." *Id.* Declining to recognize a medical peer review privilege in federal discrimination cases provides a strong evidentiary benefit. Balancing the interests to be derived from recognizing the privilege against the interest of furthering the discovery of probative and

relevant evidence to root out invidious discrimination, we decline to recognize the privilege.

Scope of Discovery

Although the district court announced its recognition of the privilege, it still ordered some limited discovery. Adkins sought to compel production of peer review materials of *all* physicians at HMC during the seven-year period that he was employed there. The district court limited Adkins' inquiries to those involving physicians in the Department of Surgery and to the five-year period preceding his suspension.

We generally review the district court's efforts to manage discovery for abuse of discretion. *Burger King Corp. v. Weaver*, 169 F.3d 1310, 1315 (11th Cir. 1999). However, if we find that in limiting discovery, the district court "made a clear error of judgment . . . or . . . applied an incorrect legal standard," we must reverse that decision. *Peat, Inc. v. Vanguard Research, Inc.*, 378 F.3d 1154, 1159 (11th Cir. 2004) (citing *Alexander v. Fulton County*, 207 F.3d 1303, 1326 (11th Cir. 2000)). Here, we find that the district court made such an error in concluding that review of physicians outside Adkins' department and beyond the five-year time limit was not relevant to the case at the bar.

Under the Federal Rules of Civil Procedure, discovery is limited to "matter[s], not privileged, that [are] relevant to the claim or defense of any party." Fed. R. Civ. P. 26(b)(1). "Relevant information need not be admissible at the trial if the discovery appears reasonably calculated to lead to the discovery of admissible evidence." *Id.* In this case, HMC argues that

adverse employment action was taken against Adkins in light of his performance during his tenure. By arguing that his record fell below standards the hospital used to judge its physicians, HMC itself put the record and peer review of other physicians at issue. Comparison to disciplinary measures against them is therefore clearly relevant to the case.

HMC argues that any comparison should be limited to physicians in the Department of Surgery since they are the only ones that are "similarly situated" to Adkins. *See Wilson v. B/E Aerospace Inc.*, 376 F.3d 1079, 1091 (11th Cir. 2004). We do not agree. While the Department of Surgery is an autonomous unit within the Hospital, some of the infractions at issue arose from hospital-wide rules, such as the requirement to complete medical charts in a timely manner. Additionally, Adkins is entitled to compare the general standard that hospital physicians were held to in order to establish that his punishment was excessive. The limited number of physicians in the Department of Surgery does not allow Adkins to place his case in the context of larger disciplinary processes of the hospital and thus place an excessive burden on his ability to pursue his claim.

We note that although district courts have broad discretion in fashioning discovery rulings, they are bound to adhere "to the liberal spirit of the [Federal] Rules." *Burns v. Thiokol Chem. Corp.*, 483 F.2d 300, 305 (5th Cir.1973). The Federal Rules do not give district courts "blanket authorization . . . to prohibit disclosure of information whenever it deems it advisable to do so, but is rather a grant of power to impose conditions on discovery in order to prevent injury, harassment, or

abuse of the court's processes." *Williams v. City of Dothan, Ala.* 745 F.2d 1406, 1416 (11th Cir. 1984) (quoting *Bridge C.A.T. Scan Assocs. v. Technicare Corp.*, 710 F.2d 940, 944-45 (2d Cir. 1903)). The Defendants have failed to demonstrate a burden or an abuse of process sufficient to justify such limitations on discovery, especially in light of the highly relevant nature of the materials sought by Adkins. Although we acknowledge that the district court's limits were aimed in part at protecting the confidentiality of Defendants' documents, these limits excessively narrowed the scope of discovery. We therefore conclude that Adkins was entitled to greater latitude in order to access documents relevant to his discrimination claim, and the district court erred by denying Adkins the opportunity to compel production of a wider range of documents.

Summary Judgment

Adkins further challenges the district court's grant of summary judgment in favor of Defendants. In light of the improper limitations on Adkins' ability to conduct discovery, we conclude that Adkins was denied the opportunity to proffer evidence in response to the summary judgment motion. *Burns*, 483 F.2d at 308 n.11. We therefore vacate the grant of summary judgment in order to allow the parties to engage in discovery in accordance with this opinion. Accordingly, the decision of the district court is vacated and remanded.

VACATED AND REMANDED.

Footnote

[1]Georgia requires that "[t]he proceedings and records of medical review committees shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by such committee." O.C.G.A. § 31-7-143. The Georgia Supreme Court has interpreted this statutory mandate as placing "an absolute embargo upon the discovery and use of all proceedings, records, findings, and recommendations of peer review groups and medical review committees in civil litigation." *Emory Clinic v. Houston*, 258 Ga. 434, 369 S. E. 2d 913, 913 (1988) (per curiam).

11/10/04
5:04-CV-80 (WDO)
IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION

DR. RUSSELL ADKINS, Plaintiff
v.
THE HOSPITAL AUTHORITY OF HOUSTON COUNTY, et al., Defendants

ORDER

This matter is before the court on the defendants' motion for protective order. Defendants seek to protect from discovery the documents pertaining to the peer review proceedings conducted at Houston Medical Center. After a thorough review of the documents in question and after careful consideration of the parties' briefs and arguments presented during the hearing, the court enters the following order.

Plaintiff, Dr. Russell Adkins, filed this suit against the Hospital Authority of Houston County and members of Houston Medical Center's Medical Executive Committee claiming that his hospital privileges were suspended in violation of 42 U.S.C. § 1981, and several state laws. Prior to the suspension of his privileges, the hospital conducted what is known as a "peer review" process during which certain allegations against Dr. Adkins were investigated. After the peer review process concluded, the Hospital Authority voted to suspend Dr. Adkins' relieve it of the obligation to respond to the discovery requests. This motion may be considered by the court when the discovery sought

would cause "undue burden or expense" on the party from whom the information is sought. Id. at (c). Federal Rule of Evidence 501 provides that ". . . the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience."

The district court has broad discretion to control discovery. Phipps v. Blakeney , 8 F.3d 788, 790 (11th Cir.1993). District courts have "the ability ... to police discovery simply and speedily." Id. For example, the court can order "that certain matters not be inquired into, orthatthescope of the disclosure or discovery be limited to certain matters." Id.

The Eleventh Circuit Court of Appeals has not addressed the issue of a "peer review" privilege in the context of a discrimination case. However, there is some guidance from the Supreme Court on how district courts are to determine whether to recognize certain privileges. Finally, there is some case law from the district courts in this circuit and others that have addressed the peer review privilege specifically.

One of the leading cases that explains the process of recognizing an evidentiary privilege is Jaffee v. Redmond, 518 U.S. 1, 116 S. Ct. 1923, 135 L.Ed.2d 337 (1996). In Jaffee, the Supreme Court for the first time recognized a privilege protecting confidential communications between a psychotherapist and her patient. After noting that, generally, evidentiary rules disfavor privileges, the court analyzed the following factors to determine whether the privilege should be

recognized exceptions from the general rule may be justified by a public good that transcends the normally predominant principle of utilizing all rational means for ascertaining the truth;

2. federal courts are governed by common law principles that are to be applied in light of reason and experience;
3. a consensus among the States regarding whether a privilege should be recognized is an important factor for courts to consider;
4. courts should make the decision whether to recognize a privilege on a case-by-case basis;
5. the mental health of our citizenry, no less than its physical health, is a public good of transcendent importance;
6. consider the likely evidentiary benefit that would result from the denial of the privilege;
7. determine whether the privilege is rooted in the imperative need for confidence and trust; and
8. consider that the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected because an uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.

Doe v. UNUM Life Ins. Co. of America involved a dispute between a physician and his insurer over the physician's alleged drug use prior to applying for disability insurance. Doe v. UNUM Life Ins. Co. of America, 891 F. Supp. 607 (N. D. Ga.1995). As part of the discovery process, the insurer sought information

from a hospital regarding why the physician's hospital privileges had been suspended. The physician and non-party hospital filed a motion to quash the subpoena arguing that the materials were protected by the peer review privilege. The court, recognizing that Georgia has legislatively and judicially adopted the peer review privilege, granted the hospital's motion for a protective order. The court first noted that the Georgia statutes "place an exceedingly wide blanket of confidentiality over information generated by health care providers concerning the quality and efficiency of medical care." Id. at 609. The court explained that "the peer review statutes confer upon peer review organizations the qualities of a black hole; what goes in does not come out, and, unless the information exists in duplicate in the surrounding orbit, nothing that went in is discoverable." Id. at 610.

In the case bar, the defendants established several compelling reasons to recognize the peer review privilege under the particular circumstances of this case. First, all of the factors listed above from Jaffee are met. Second, it is certainly in the interest of the public that the documents at issue be protected from disclosure. The peer review process, as it relates to the plaintiff and the other physicians, serves as an integral part of the hospital's fulfillment of its duty to provide the best health care available and to ensure that any physicians who, for whatever reason, are not performing up to the hospital's expectations are subjected to a suspension of their hospital privileges.

As for the other factors, another compelling reason to recognize the privilege in this case is that the State of Georgia has unequivocally created a privilege for all

matters emanating from the medical peer review process. See O.C.G.A. §§ 31-7-133, 31-7-143. Further, the numerous cases cited by the defendants show that all 50 States and the District of Columbia have adopted some form of the privilege and 46 of those States have enacted legislation recognizing the privilege. See Weekoty v. United States, 30 F. Supp.2d 1343, 1346 (D.N.M. 1998) (citing Sanderson v. Frank S. Bryan, M.D., Ltd., 361 Pa. Super. 491, 495 n. 3, 522 A.2d 1138, 1140 n. 3 (Pa. Super. Ct.1987)). Therefore, the defendants established a consensus among the States that the privilege should be recognized. There is little or no evidentiary benefit that would result from the denial of the privilege in this case because the information the plaintiff seeks may very well be obtained from other sources such as through depositions of hospital administrators regarding general information about the hospital's policies and procedures for the peer review process and whether other individuals have been subjected to the same. Finally, the defendants' desire to protect the peer review documents is rooted in the imperative need for confidence and trust because this case involved a group of physicians passing judgment on their colleagues who had been accused of various wrongdoings or omissions.

After careful thought and reflection on the above factors and consideration of the parties' arguments, the court hereby GRANTS the defendants' Motion for Protective order as to all peer review materials requested by the plaintiff. See R. at 56. However, this order does not prohibit either party from using any information in their possession to support or defend any claims asserted in this case. The court will leave it up to the parties to decide whether to disclose the

confidential materials in their possession.

Finally, because the court returned all documents that were submitted for in camera review, other than the peer review materials that pertain specifically to the plaintiff, the plaintiff's Motion for Leave to Submit Information Under Seal is DENIED AS MOOT. See R. at 79.

SO ORDERED this 10th day of November, 2004.

WILBUR D. OWENS, JR.
UNITED STATES DISTRICT JUDGE

5/2/06
UNITED STATES DISTRICT JUDGE
5:04-CV-80 (WDO)

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

RUSSELL ADKINS, M.D.,
Plaintiff
v.

THE HOSPITAL AUTHORITY OF HOUSTON COUNTY, et al.,
Defendants

ORDER

Dr. Russell Adkins brought this case alleging that his hospital privileges at Houston Medical Center were suspended because of his race, African-American. He sued the hospital, numerous doctors, the Hospital Administrator and the governing authority of the hospital, the Hospital Authority of Houston County, asserting claims pursuant to 42 U.S.C. § 1981, § 1983 and § 1985(3) as well as various state law claims. As to the § 1983 claims, Dr. Adkins contends that (1) the Defendants violated his right to equal protection by summarily suspending and not renewing his privileges based on his race and (2) the Defendants took these actions without affording him due process. The § 1981 claims are that the Defendants discriminated against Dr. Adkins in the making, performance and enforcement of his contractual relationship with his patients. The §1985 claims are that the Defendants conspired to deprive Dr. Adkins of various

constitutional rights. Defendants filed motions to dismiss arguing that Dr. Adkins failed to state a claim on which relief can be granted and on the basis of qualified immunity. The Court declined to rule on the motion to dismiss and instead ordered the parties to engage in discovery and thereafter file motions for summary judgment. After an extensive discovery period, the Defendants have now moved for summary judgment. After carefully considering the entire record, the Court finds that another hearing is unnecessary and makes the following findings.

The Medical Executive Committee of Houston Medical Center is the representative body for the hospital's medical staff and consists of officers of the medical staff and the Chairmen of the various departments. One of the MEC's duties is to review the qualifications, credentials, performance, professional competence and character of applicants and staff members and make recommendations to the Hospital Authority regarding staff appointments, clinical privileges and corrective actions. The Hospital Authority independently reviews the physicians' files and makes independent decisions regarding whether to approve or deny the MEC's recommendations. Pursuant to the Bylaws, "The Hospital Authority may affirm, modify or reverse the prior decision or, in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within ten (10) business days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specified issues."[1] The MEC may summarily suspend a physician when it feels action must be taken immediately to protect the health or safety of patients.

Pursuant to the hospital's bylaws, each Department in the hospital is an autonomous unit that formulates its own policies and procedures and has its own Department Chair. The Chair of each Department examines the licensure, character, professional competence, qualifications and ethical standing of physicians applying for privileges within that Department. The Departments, as much as is practical, are autonomous units coordinating their efforts through the Medical Executive Committee and other Committees of the Staff as necessary for administrative functioning. Each Department establishes criteria for the granting of Clinical Privileges within the Department and submits recommendations regarding the specific Clinical Privileges each Staff Member or Applicant may exercise. Each Department adopts a written Departmental code containing rules and regulations that are reviewed, amended and approved by each Department. The Department of Surgery is listed as a separate department that did in fact adopt its own Rules and Regulations.

In 1997, Dr. Adkins applied for provisional medical staff membership in the Department of Surgery at Houston Medical Center. The application was approved subject to the standard provisions that he consult with another surgeon on the first 25 patients admitted to the hospital and be observed by another surgeon on the first 10 surgeries performed at the hospital. In early 1998, the Hospital Authority approved Dr. Adkins' application for provisional active staff membership. During the provisional period, Dr. Adkins experienced problems with being available for call, following preadmission protocol and completing his medical records on time. For instance, the hospital required patients who were

undergoing surgical procedures to have consents and blood work done prior to the day of surgery. However, Dr. Adkins would not require his patients to follow these rules which would result in his patients' surgeries and the schedule for the entire Department of Surgery being delayed and the need for additional staff. When Dr. Adkins later applied to change from a provisional status to active status, the MEC recommended that the Hospital Authority extend Dr. Adkins' provisional status for 6 months to monitor his performance in following preadmission protocol. In 1999, the Hospital Authority extended his provisional status for 6 months so he could be monitored on preadmission protocol, timely completion of medical records and availability for and timely response to calls from the hospital. At the end of the provisional period, Dr. Adkins' status changed to "active" membership.

In June of 2001, Dr. Harvey, the Chief of Staff at the time, was contacted by Outpatient Surgery when no one was able to reach Dr. Adkins regarding one of his surgical patients who was experiencing complications in the recovery room. Dr. Harvey beeped Dr. Adkins and received no response. Dr. Harvey then contacted Dr. Adkins' office and learned that Dr. Adkins had left the call area without arranging for anyone to cover for him. Dr. Adkins contends his pager was not working properly at the time. Following an investigation, Dr. Adkins received a letter of admonishment regarding his unavailability.

In late 2001, Dr. Adkins submitted his application for reappointment. The Credentials Committee determined that (1) Dr. Adkins' attendance at medical staff meetings fell below the 50% required by the Bylaws, (2)

Dr. Adkins continued to have problems being available for calls and (3) Dr. Adkins had multiple suspensions for failure to timely complete his medical records. As a result, his reappointment was granted with the stipulations that he attend 100% of his meetings for 6 months and that his medical charts would be monitored for 6 months.

In March of 2002, Dr. Adkins posted a surgical case on the bulletin board for a 7-month-old male patient to perform an open procedure to repair an obstruction in the infant's kidney that was diagnosed in January of 2002. The anesthesiologist who reviewed the posting informed Dr. Adkins that such a procedure was not appropriate at Houston Medical Center because it is not a pediatric facility and is not properly equipped to handle any complications which could arise. Rather than transferring the child to another facility, which was an option considering the matter was not an emergency, Dr. Adkins removed the posting from the schedule and proceeded to perform a closed procedure of placing a stint in the child's kidney. Because of complications that arose during the surgery, Dr. Adkins was unable to perform the surgery and, rather than transferring the child to another facility, ordered the nurse to procure an adult uretaoscope and adult male dialotors. When the nurse questioned Dr. Adkins about using adult male instruments on the infant, Dr. Adkins ordered her to do as she was told because the infant's penis is a "muscle that would stretch." Dr. Adkins used the adult instruments to manipulate the child's urethra but lost the stint inside the child before it could be placed. Dr. Adkins eventually retrieved the stint and placed it. Following this procedure, internal complaints were made by the operating room personnel to the

Department of Surgery and an investigation ensued.

Dr. Alford, the Medical Director and a Defendant in this case, conducted the investigation. He interviewed the personnel involved in the surgery and attempted to interview Dr. Adkins but Dr. Adkins refused to discuss the matter after he was informed that Dr. Alford intended to tape-record the interview, as he had done in all the other interviews. After Dr. Alford completed the investigation, he submitted the transcribed witnesses' statements and the pertinent medical records to the Performance Improvement Committee ("PIC"). The PIC sent the matter out for two external peer reviews that resulted in the following findings:

- the procedure was not emergent;
- Dr. Adkins' decision to perform the procedure was inappropriate as the procedure of choice for an infant male in that situation rarely requires temporary drainage but requires a procedure that would avoid trauma to the infant's lower urinary tract;
- there were concerns regarding the management of the infant and not being able to confirm adequate instruments were available before the procedure began;
- the dilation of the urethra and distal ureter in a male infant was inappropriate even though the outcome may not be immediately apparent; and
- potential future problems for the baby include permanent disability with recurrent stricture, incontinence, urinary tract infections, renal insufficiency and the need for multiple corrective surgeries.

From these findings, the external peer reviewers concluded that (1) the documentation did not support

the need for surgery, (2) the diagnosis was confirmed, (3) the surgical technique was not appropriate, (4) the procedure was not appropriate, (5) the medical judgment was not appropriate and (6) there was an error in judgment and technique. The Department of Surgery submitted the reports to the Credentials Committee. Those reports along with those of the PIC were sent to the MEC. The MEC thereafter invited Dr. Adkins to meet with them to discuss the findings. Dr. Adkins met with the MEC and, following that meeting, the MEC restricted Dr. Adkins, as well as the other two urologists at the hospital, from performing any future complex pediatric cases at the hospital unless they were cleared by the Department Chairman.

A few months later, the PIC received a complaint from a female patient regarding another surgery performed by Dr. Adkins. Because the patient returned to surgery within 31 days of admission the case triggered a Departmental peer review, as the record shows happened with any patient who presented to the hospital within 31 days of a previous admission. The case was referred to the PIC. After the initial complaint, the patient also filed a complaint with the Joint Commission for Healthcare Accreditation Organization ("JCHAO"). The JCHAO requested a response from the hospital pursuant to which the MEC formed an Ad Hoc committee to investigate the matter.

As a result of the investigation, the hospital learned that Dr. Adkins had performed a bladder sling and a rectocele procedure on the patient on June 24, 2003. Three weeks after the procedure, the patient was still experiencing bleeding and eventually noticed surgical gauze hanging out of her vagina. Upon discovering the

gauze, the patient went to Dr. Adkins' office where he examined her and determined that he needed to oversew the incision area because the gauze was grafting material he had used during the surgery.[2] The following morning, the patient awoke covered in a pool of blood and realized she was bleeding profusely from her vagina. The patient's husband took her to the emergency room and informed the doctors that Dr. Adkins had operated on her three weeks previously and had seen her the day before to repair the incision area. Because the patient was in horrible pain, she refused to allow the emergency personnel to examine her and Dr. Adkins was contacted. The patient requested to speak with Dr. Adkins on the telephone and when she did Dr. Adkins told her he was out of own and that she needed to allow the emergency room physician to examine her. Dr. Adkins admitted in his discovery responses that he was in fact more than 30 miles from the hospital on that date. The emergency personnel attempted to examine the patient again and she refused due to the extreme pain so Dr. Adkins was contacted again. Over the phone, Dr. Adkins admitted the patient and ordered pain medication for her. However, he did not inform any hospital personnel that he was out of town or that he had asked Dr. Deighton to cover for him, although Dr. Deighton was informed he needed to cover for Dr. Adkins beginning on Saturday and the patient came into the emergency room on Thursday. Later in the afternoon, the nursing staff contacted Dr. Adkins regarding the patient's bleeding and continual complaints of pain. Dr. McBride, the surgeon on call, was contacted, evaluated the patient and contacted Dr. Deighton to examine the patient as her problem was urological. Three hours later, Dr. Adkins finally arrived at the hospital and reported to the operating room

where Dr. Deighton was about to begin operating on the patient. Dr. Deighton offered to turn the matter over to Dr. Adkins but Dr. Adkins asked Dr. Deighton to proceed with the surgery because he was already scrubbed and ready. After the surgery, Dr. Deighton replaced Dr. Adkins as the patient's physician.

After conducting the investigation into the complaints regarding the female patient, the PIC made the following findings:

- in violation of the Bylaws, Dr. Adkins admitted a patient when he could not respond appropriately and failed to inform the hospital that anyone was covering for him;
- Dr. Adkins failed to timely complete the patient's medical records as her June 24-27, 2003 admission was not dictated until September 9, 2003;
- there was an extreme discrepancy in the amount of blood loss reported by the anesthesiologists and indicated by Dr. Adkins in the medical records;
- Dr. Adkins operated on a patient and left town without arranging for appropriate coverage;
- the external peer review had also noted problems with the medical records, the discrepancy in the blood loss reported, the lack of follow-up care after surgery and the lack of any note in the medical record regarding the July 16 admission;
- there were reports that Dr. Adkins discussed the patient's care with her husband in the hallway where other individuals could overhear the conversation; and
- all of the aforementioned issues demonstrated a lack of professional judgment.

In September of 2003, the MEC recommended renewal

of Dr. Adkins' privileges with warnings regarding his timeliness of completing reports and his availability. He was notified that his patients would be monitored by another physician for 6 months. The Hospital Authority rejected the limited renewal recommendation and requested the MEC to reconsider its recommendation after receiving the final report regarding Dr. Adkins' treatment of the female patient. At the October 6, 2003 meeting, the MEC voted to suspend Dr. Adkins for 60 days, the reasons given for which were that the suspension was in furtherance of quality healthcare and to protect the health and safety of patients at the hospital. The MEC also recommended that the Hospital Authority deny Dr. Adkins' application for reappointment. Dr. Adkins was informed of the adverse action and advised of his hearing rights. Dr. Adkins declined, in writing, to attend or otherwise participate in the hearing. On March 22, 2004, the Hearing Committee recommended denying Dr. Adkins' application for reappointment. After reviewing the recommendation, the MEC voted to summarily suspend Dr. Adkins for 60 days and recommended that the Hospital Authority deny Dr. Adkins' application. The Hospital Authority accepted the recommendation and Dr. Adkins' privileges were suspended.

After Dr. Adkins filed this suit against the Defendants and the parties began to engage in discovery, serious issues arose regarding the scope and relevance of the discovery sought by Dr. Adkins. After several hearings and orders, the Court eventually ordered Defendants to produce discovery related only to events that occurred within 5 years of Plaintiff's termination, from May 26, 1999 to May 26, 2004, and only on those individuals who were "similarly situated" to Dr. Adkins, as explained

more thoroughly below. Defendants produced redacted information to Plaintiff regarding the incidents that occurred with other physicians who were disciplined in some way and produced Dr. Adkins' peer reviews. The actual peer reviews and credentialing files of the other physicians were produced to the Court for an in camera review and covered periods of time far beyond that ordered by the Court.[3] Based on the foregoing factual findings and a thorough examination of the peer review material submitted in camera, the Court makes the following legal findings.

Qualified Immunity

Defendants raised the defense of quality immunity. That is, Defendants claim that Dr. Adkins failed to allege a custom, policy or practice of the hospital that was the moving force of any constitutional violation and failed to show that the individual Defendants violated any of Dr. Adkins' clearly established constitutional rights. The Hospital Authority and the individual Defendants are "state actors" pursuant to Faucher v. Rodziewicz, 891 F.2d 864, 868 (11th Cir. 1990). Although the individual Defendants argue that some of them should not have been sued because they did not attend certain meetings or attended and abstained from voting at the meetings, for purposes of this order the Court finds they were all "government actors."

"Local governing bodies ... can be sued directly under § 1983 for monetary, declaratory, or injunctive relief where. . . the action that is alleged to be unconstitutional implements or executes a policy statement, ordinance, regulation, or decision officially adopted and promulgated by that body's officers."

Monell v. Department of Social Services, 436 U.S. 658, 690, 98 S. Ct. 2018 (1978). Courts may not hold a party, such as the hospital in this case, liable solely under a theory of respondent superior. Id. at 691. The threshold inquiry a court must undertake in a qualified immunity analysis is whether a plaintiff's allegations, if true, establish a constitutional violation. Hope v. Pelzer, 536 U.S. 730, 736, 122 S. Ct. 2508, 153 L. Ed.2d 666 (2002) (citing Saucier v. Katz, 533 U.S. 194, 201, 121 S. Ct. 2151, 150 L. Ed.2d 272 (2001)). If no constitutional right was violated, "there is no necessity for further inquiries concerning qualified immunity." Saucier, 533 U.S. at 201. The qualified immunity defense "embodies an `objective reasonableness' standard, giving a government agent the benefit of the doubt," provided that the conduct was not "so obviously illegal in the light of then-existing law. Crosby v. Paulk, 187 F.3d 1339, 1344 (11th Cir. 1999) (quoting GJR Invs., Inc. v. County of Escambia, 132 F.3d 1359, 1366 (11th Cir. 1998)). The circumstances that confronted the government actor must have been so "materially similar" to prior precedent that it constituted clearly established law because "public officials are not obligated to be creative or imaginative in drawing analogies from previously decided cases." Id. (citations omitted). "For qualified immunity to be surrendered, pre-existing law must dictate, that is, truly compel (not just suggest or allow or raise a question about), the conclusion for every like-situated, reasonable government agent that what defendant is doing violates federal law in the circumstances." Id.

Generally, in analyzing §1981 and §1983 claims, courts follow the same burden-shifting framework used in Title VII cases. Standard v. A.B.E.L. Services, Inc., 161

F.3d 1318 (11th Cir. 1998) (Title VII and 42 U.S.C. § 1981 and § 1983 have the same requirements of proof and use the same analytical framework.); McDonnell Douglas Corp. v. Green, 411 U.S. 792, 802, 93 S. Ct. 1817, 36 L. Ed.2d 668 (1973). However, Dr. Adkins' §1981 claims must be dismissed because § 1983 is the exclusive federal remedy for alleged § 1981 violations when the claim is pressed against a state actor. Jett v. Dallas Independent School Dist., 491 U.S. 701, 735 (1989); Butts v. County of Volusia, 222 F.3d 891, 894 (11th Cir. 2000) (Civil Rights Act of 1991 did not affect the continuing validity of Jett). Finally, because public officials cannot raise a qualified immunity defense to a § 1985(3) claim, that claim is addressed separately below. Burrell v. Board of Trustees of Ga. Military College, 970 F.2d 785, 794 (11th Cir. 1992).

The threshold inquiry this Court must undertake is whether Dr. Adkins' allegations, if true, establish a constitutional violation. If he has not shown that any of his constitutional rights were violated, there is no necessity for further inquiries concerning qualified immunity and the Court must grant summary judgment in favor of Defendants. Since the qualified immunity defense embodies an objective reasonableness standard, the Court must give the Defendants the benefit of the doubt, provided that Dr. Adkins' termination was not obviously illegal in light of then-existing employment discrimination law.

"Direct evidence of discrimination is evidence, that, `if believed, proves the existence of a fact in issue without inference or presumption.'" Vickers v. Federal Express Corp., 132 F. Supp.2d 1371, 1378 (S.D. Fla. 2000) ("Racially derogatory statements can be direct

evidence if the comments were (1) made by the decisionmaker responsible for the alleged discriminatory act and (2) made in the context of the challenged decision.") (quoting Burrell v. Board of Trustees of Ga. Military College, 125 F.3d 1390, 1393 (11th Cir.1997)). Such evidence is generally comprised of specific statements, conduct or attitudes by employment decision makers that reflect a bias or discriminatory animus toward a particular protected class. Dr. Adkins presented no evidence of any statements or other conduct by the Defendants that indicated Dr. Adkins was suspended because he is an African-American nor is there any evidence in the record that could be construed as direct evidence of discrimination.

"Where direct evidence of discrimination is absent, a plaintiff establishes a circumstantial, prima facie case of racial discrimination based on disparate treatment by showing several things: (1) he belongs to a racial minority; (2) he was subjected to [an] adverse job action; (3) his employer treated similarly situated employees outside his classification more favorably; and (4) he was qualified to do the job." Knight v. Baptist Hosp. of Miami, Inc.,, 330 F.3d 1313, 1316 (11th Cir. 2003) (citing Holifield v. Reno, 115 F.3d 1555,1561-62 (11th Cir. 1997) (citing McDonnell Douglas Corp. v. Green, 411 U.S. 792, 93 S. Ct. 1817, 1824-25, 36 L.Ed.2d 668 (1973))). Dr. Adkins satisfied the first, second and fourth prongs of a prima facie case. What the court must determine is whether Dr. Adkins was suspended or disciplined for conduct that similarly situated, non-AfricanAmerican physicians were not.

Although Dr. Adkins concedes he had a continuing

problem completing his medical records on time, he contends other physicians had the same problems and that he handled his surgical cases in the manner he thought was appropriate at the time. However, the record shows that the entire time he was employed at the hospital he continually violated the written policies and procedures as alleged by the Defendants. What is important is that these events were documented in the record but even if the events did not actually occur, they can be considered if the decision-makers honestly believed they occurred. Knight, 330 F.3d at 1318 n.6 (citing Jones v. Gerwens, 874 F.2d 1534, 1540 (11th Cir.1989) ("The law is clear that, even if a Title VII claimant did not in fact commit the violation, an employer successfully rebuts any prima facie case of disparate treatment by showing that it honestly believed the employee committed the violation.")). An employer's legitimate, nondiscriminatory reason, even if based on a mistaken belief, will not subject an employer to liability if that belief is subsequently proven to be an incorrect one. Moore v. Sears, Roebuck & Co., 683 F.2d 1321, 1323 n.4 (11th Cir. 1982) (the court "need only determine that the defendant in good faith believed plaintiff's performance to be unsatisfactory") (citations omitted). An employer has a right to interpret its rules as it chooses and to make determinations as it sees fit under those rules because the anti-discrimination statutes only prohibit discrimination. Nix v. WLCY Radio/Rahall Communications, 738 F.2d 1181, 1187 (11th Cir. 1984) (citation omitted).

The Eleventh Circuit Court of Appeals has admonished, "federal courts do not sit as a super-personnel department that reexamines an entity's

business decisions. No matter how medieval a firm's practices, no matter how high-handed its decisional process, no matter how mistaken the firm's managers, [courts do] not interfere. Rather our inquiry is limited to whether the employer gave an honest explanation of its behavior." Chapman v. AI Transport, 229 F.3d 1012, 1030 (11th Cir. 2000) (citation omitted). Federal courts "are not in the business of adjudging whether employment decisions are prudent or fair." Id. (citation omitted). "An `employer may fire an employee for a good reason, a bad reason, a reason based on erroneous facts, or for no reason at all, as long as its action is not for a discriminatory reason.'" Id. (citing Nix v. WLCY Radio/Rahall Communications, 738 F.2d 1181, 1187 (11th Cir.1984)). Often mistaken for more than what it is, most plaintiffs fail to comprehend that the anti-discrimination statutes are not federal civility codes. Mendoza v. Borden, Inc., 195 F.3d 1238, 1245 (11th Cir. 1999). Those laws simply do not extend to every action that makes an employee or former employee unhappy. Davis v. Town of Lake Park, 245 F.3d 1232, 1242 (11th Cir. 2001). Therefore, Dr. Adkins cannot prove discrimination by allegations of unfairness or showing he disagreed with the Defendants' interpretation of the hospital's rules. Dr. Adkins must show he was discriminated against because of his race by being suspended for similar or comparable conduct for which non-African-American physicians were not.

In Holifield v. Reno, the Eleventh Circuit addressed a case where an African-American physician sued the Bureau of Prisons after he was removed from his position at the Federal Correctional Institution in Marianna, Florida. Holifield v. Reno, 115 F.3d 1555 (11 th Cir. 1997). In its analysis of the plaintiff's claims, the

court noted that a "plaintiff must show that his employer treated similarly situated employees outside his classification more favorably than [him]self." Id. at 1562 (citation omitted). "To make a comparison of the plaintiff s treatment to that of non-minority employees, the plaintiff must show that he and the employees are similarly situated in all relevant respects." Id. (citations omitted). In determining whether employees are similarly situated for purposes of establishing a prima facie case, it is necessary to consider whether the employees are involved in or accused of the same or similar conduct and are disciplined in different ways. Id. (citations omitted).

The court compared the actions taken against the plaintiff to those taken against other physicians at the facility, "[r]ecognizing, however, that these are only a limited number of potential `similarly situated employees' when higher level supervisory positions for medical doctors are involved." Id. at 1563. The court distinguished the two comparators on the conduct complained of and found their conduct legally distinguishable. In response to the plaintiff's claim that other staff members "felt racism played a part in decisionmaking by the administration, and that not enough African-Americans were in positions of authority" at the facility, the court held that "the alleged biases of other staff members are not relevant. The biases of one who neither makes nor influences the challenged personnel decision are not probative in an employment discrimination case." Id. at 1563 (citations omitted).

In Anderson v. WBMG-42, the court held that comparators were similarly situated when they "fell

within the primary responsibility of one middle manager and the same supervisory chain of command." Anderson v. WBMG-42, 253 F.3d 561, 566 (11th Cir. 2001). However, the court rejected the defendants' broad assertion that "a plaintiff cannot prevail as a matter of law whenever two different supervisors are involved in disciplining the plaintiff and comparators." Id. The court noted that the involvement of two or more supervisors is simply one consideration for the court to make in determining whether a plaintiff was similarly situated to the comparators. Id.

The record clearly establishes that Dr. Adkins violated the various policies and procedures, written and unwritten, as alleged by the Defendants. There is absolutely no evidence whatsoever in the record that any of the Defendants applied the policies in a discriminatory manner. Dr. Adkins failed to identify a single similarly situated physician (surgeon, urologist or any other) who engaged in conduct comparable to that of Dr. Adkins, particularly considering the reprehensible conduct involving the surgery on the 7-month-old male patient. Dr. Adkins failed to show that the decisionmakers involved in his case knew about the alleged instances of misconduct by the other physicians. He failed to show that any of those individuals had their cases submitted to the same peer review panels or outside review boards. The record clearly shows that the hospital closely managed concerns with patient care, failure to timely complete medical records and any other ways in which a physician may violate the bylaws. For instance, one physician who had a case sent to peer review for various problems had a clearly distinguishable trait - the physician saw a problem during surgery and immediately ceased operating on

the patient, rather than proceeding with a surgery knowing there could be serious consequences. The same physician had a patient experience problems with severe blood loss but the blood loss was related to another individual prescribing the wrong medication. Another surgeon had a patient experience postoperative difficulties but the surgeon immediately responded to and remedied the problem. Two other physicians were disciplined for unprofessional conduct for responding to a hospital call after consuming alcoholic beverages. They were prohibited from serving in any elected office and from chairing any committees at the hospital. Another physician was fined for withholding information from a colleague's medical records. The evidence clearly establishes that the hospital applies its bylaws and standards of conduct to all physicians who violate the same without regard to a physician's race.

Dr. Adkins was unable to give clear examples of non-African-American doctors being treated more favorably under similar circumstances. His responses were: "I've known cases that were worse" and "I can't recall the names or whatever but I know for a fact."[4] His attempt as explaining that response was "I just know I have been treated differently, okay? That's the only thing I can tell you.... I can't get into specific dates and specific cases, but I've understood from staff in the hospital certain things.... I just know I'm treated differently. Okay? That's the best I can do."[5] The only specific examples he gave at that time was where another physician's patient had come into the emergency room because of a gunshot wound. Tragically, that patient died but Dr. Adkins failed to show how that particular doctor was treated more favorably in relation to any

peer review of the issue. Dr. Adkins also mentioned a case where another physician was accused of having sexual relations with one of his employees and abusing his prescription-writing privileges. The hospital suspended the physician, as did the Composite State Board, for 90 days. Dr. Adkins failed to point to any non-African-American physicians engaged in worse conduct than Dr. Adkins yet were not disciplined. Rumors, conclusory allegations and a plaintiff's subjective beliefs about the conduct of allegedly "similarly situated" individuals "are wholly insufficient evidence to establish a claim of discrimination as a matter of law." Mitchell v. Toledo Hosp., 964 F.2d 577 (6th Cir. 1992).

One of Dr. Adkins' primary disagreements with the Defendants is the issue of his availability, or lack thereof, to attend to the matter with the female patient. Dr. Adkins maintains that he adequately cared for the patient and "told people" he would be out of town but that they could contact him. The practice of the hospital was that the physician himself is ultimately responsible for notifying the Emergency Room if he is going to be out of town. Further, when a physician is called by the ER about one of his patients with an emergency condition, if that physician did not want to or was unable to care for the patient, the physician must let the ER know another physician is covering for him, and identify who that other physician will be. Further, when a physician admits a patient into the hospital, that physician is designating himself as the individual who will provide the primary care for the patient. If that physician is unable to care for the patient it is his responsibility to inform the hospital if there is someone different who will be taking care of the patient post

admission.[6] The record clearly shows that Dr. Adkins failed in every one of these responsibilities. He gave conflicting stories to his office and some individuals at the hospital regarding where he was going and when he was going out of town. Further, it was hours after the patient was readmitted to the hospital that Dr. Adkins finally arrived only to find that another physician had stepped in and taken care of Dr. Adkins' patient. Dr. Adkins cannot in light of the evidence before this Court deny that he failed in these responsibilities.

One important item of evidence is the list of physicians who in the last five years had their hospital privileges suspended at Houston Medical Center. That list shows the hospital evenly applies the rules to all physicians. The physicians who had been suspended were: 6 African American, 32 Caucasian and 9 Asian, all for various types of offenses. Of course, there is not an exactly equal number of physicians in those categories but the list is telling - the hospital has no problem disciplining physicians whose race is something other than African-American. The peer reviews of the physicians show the Hospital Authority takes substandard patient care, failure to attend to medical records and failure to be available for patients very seriously. If a physician violates the bylaws, or any other standard of care adopted by the various Departments, the Hospital Authority will take appropriate action against that physician by an informal file review by the Department Chair, a review by the MEC, PIC, an Ad Hoc Committee or a peer review Committee or a combination of all of the above.

Dr. Adkins failed to establish any of the Defendants violated his constitutional rights in the manner in which

he was disciplined and eventually suspended. Dr. Adkins failed to show that the Hospital Authority adopted, approved or in any way implemented policies, customs, practices or procedures that violated his constitutional rights. This is not a case where a genuine issue of material fact is created because of the subjective reasons given for the suspension of Dr. Adkins' privileges. Rather, the reasons given by the Defendants are based on written policies and procedures that the respective individual Defendants believed Dr. Adkins violated in a manner that placed patients at an increased risk of immediate and long-term harm. Dr. Adkins' only response to the Defendants' reasons for his suspension was that he believed what he did was sufficient in each case. Dr. Adkins does not dispute that the Defendants believed he used bad judgment, acted unprofessionally or violated the policies in question. Dr. Adkins simply responds that he does not feel that what he did showed bad judgment or unprofessional behavior or violated any hospital policies. This is not sufficient to defeat summary judgment in a case where the Defendants' opinion of Dr. Adkins' performance is the relevant issue. Although qualified immunity is determined under objective reasonableness standards, the individual Defendants' subjective intent is an essential element of the underlying allegation of a Constitutional violation. Defendants could not have violated Dr. Adkins' rights unless they had the intent to discriminate. Defendants suspended Dr. Adkins because they reasonably believed he violated hospital policies in a manner that jeopardized his patients' health and the efficient running of the hospital. These are lawful motivating factors. Because Dr. Adkins' suspension did not violate clearly established statutory or constitutional rights of

which a reasonable person would have known, the Defendants are entitled to qualified immunity from Dr. Adkins' § 1983 claims and to summary judgment in their favor.

Remaining Claims

Dr. Adkins claimed due process violations although it is unclear exactly how he is claiming his due process rights were violated. Any claim that Dr. Adkins is alleging is dismissed however because he failed to take advantage of the hearing process offered by the hospital and thoroughly explained to him in numerous letters from several different individuals. Faucher, 891 F.2d at 870871 (no due process claim where the plaintiff chose to address her grievances to a federal court rather than the hospital's appellate review procedures); Richards v. Emanuel County Hosp. Authority, 603 F. Supp. 81, 86 (S.D. Ga. 1984).

As to the § 1985 claim, Dr. Adkins claims the Defendants conspired to discriminate against him in the ways alleged above. The elements of a § 1985 conspiracy claim are "(1) a conspiracy; (2) for the purpose of depriving, directly or indirectly, any person or class of persons of the equal protection of the laws or of equal privileges and immunities under the laws; (3) an overt act in furtherance of the object of the conspiracy; and (4) that the plaintiff (a) was injured in his person or property, or (b) was deprived of having and exercising any right or privilege of a United States citizen." Byrd v. Clark, 783 F.2d 1002, 1007 (11th Cir. 1986) (citations omitted) (no longer good for one point of law not relevant to the case at bar). "The language of Section 1985 which requires an intent to deprive one of

equal protection or equal privileges and immunities means that there must be some racial or otherwise class-based invidiously discriminatory animus behind the conspirators' action." Id. at 1007-08. One of Dr. Adkins' examples of how the Defendants conspired against him is his allegation that Dr. Deighton was the driving force behind the female patient's complaint to the hospital and the JCHAO. That patient's deposition testimony clearly refutes this allegation. She stated that before she spoke to Dr. Deighton about her complaints regarding Dr. Adkins' care, during the time in which he was treating her after her final operation, she had already sent the initial complaint to the JCHAO. Further, Dr. Deighton did not disparage Dr. Adkins' care to the patient as alleged by Dr. Adkins. Rather, the patient testified that Dr. Deighton stated he was surprised to see an incision that large across her abdomen and that he would have done the procedure differently. When Dr. Adkins was asked in his deposition whether he felt any the other doctors were trying to take his patients, he responded, "I don't know." In fact, Dr. Adkins was never able to articulate a basis for suing any of the individual Defendants other than that he thought they were all involved in some way in the suspension of his privileges, even those who abstained from voting or who were never present for a particular committee meeting. Based on the findings related to the § 1981 claims, Dr. Adkins failed to establish a "conspiracy" for the purpose of depriving him, directly or indirectly, of the equal protection of the laws, failed to point to any overt acts in furtherance of the object of any alleged conspiracy or that he was deprived of having and exercising any right or privilege of a United States citizen. The §1985 claim is therefore dismissed.

Conclusion

Because the Court has dismissed all claims over which it has original jurisdiction, it declines to exercise supplemental jurisdiction over Dr. Adkins' state law claims, see 28 U.S.C. § 1367(c)(3), and those claims are dismissed without prejudice. Defendants' motions to dismiss and motions for summary judgment are GRANTED and judgment shall be entered in the Defendants' favor.

SO ORDERED this 2nd day of May, 2006.
S/
WILBUR D. OWENS, JR.
UNITED STATES DISTRICT JUDGE

Footnotes

[1] Art. XII, Sec. H, Par. 8.

[2] The patient stated that, during this visit, Dr. Adkins informed her he was going to Detroit the next day but Dr. Adkins denies he told her he was going out of town. The patient also testified that Dr. Adkins has since tried to convince her he never told her he was going to Detroit but the two could never agree on what was said. R. at 173, Ex. A., pp. 129, 267.

[3] Those documents will remain with the Court until 60 days after judgment is entered.

[4] plf.'s Dep. at 108.

[5] Id. at 110-114.

[6]R. at 159, p.197-198 (Depo. of Dr. Deighton, Chief of Staff). 18

No. 06-13107
UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

RUSSELL E. ADKINS, MD,
Plaintiff-Appellant,

Versus

ARTHUR P. CHRISTIE, Individually, and in his Official Capacity as the Administrator of Houston Medical Center, ANTHONY L. ALFORD, Individually and in his Official Capacity as Executive Director for Medical Affairs of Houston Medical Center, DANIEL A. DEIGHTON, Individually and in his Official Capacity as Chief of Staff and in his Official Capacity as a Member of the Medical Executive Committee at Houston Medical Center, FREDERICK W. JENNART, Individually and in his Official Capacity as a Member of the Medical Executive Committe at Houston Medical Center, DAVID N. HARVEY, MD, Individually, and in his Official Capacity as a Member of the Medical Executive Committee at Houston Medical Center, et al.,
Defendants-Appellees.

On Appeal from the United States District Court for the Middle District of Georgia

Aug 16 2007

ON PETITION(S) FOR REHEARING AND PETITION(S.) FOR REHEARTNG EN BANC

Before: EDMONDSON, Chief

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED,

ENTERED FOR THE COURT:

/s/CHARLES R. WILSON
UNITED STATES CIRCUIT JUDGE